February, 1959

HARVARD MEDICAL
ALUMNI BULLETIN

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REGIONAL ACTIVITIES

NORTH CAROLINA

On Wednesday evening, March 11, 1959, there will be an informal meeting of the Harvard Medical Alumni and their wives at the Carolina Inn, Chapel Hill, for cocktails and dinner at 6:30 o'clock. Dr. and Mrs. Lanman and Dorothy Murphy will be with us and we hope that all Alumni in and nearby Chapel Hill will attend.

William R. Pitts, '33
Vice President
Harvard Medical
Alumni Association
1012 Kings Drive
Charlotte, North Carolina

DENVER

The annual Harvard Lecture of the Rocky Mountain Harvard Medical School Alumni Association was held on October 23, 1958 in the auditorium at the Medical School of the University of Colorado and was attended by students, house staff, senior staff, and doctors from the community. C. Sidney Burwell, '19, guest lecturer, spoke on "Heart Disease and Pregnancy." Cocktails and dinner followed at the Denver Country Club, which were attended by twenty-three Alumni. At the dinner a short business meeting was held to elect Lawrence Campbell, '33, as president and George Wilcox, '46, as secretary of the Rocky Mountain H.M.S. Alumni Association. Dr. Burwell reported that he was "very much impressed with the vigor and enthusiasm of the group."

NEW YORK

The Harvard Medical Society of New York met on October 31, 1958. Seven new members were unanimously elected into the Society and a report on activities at the School was delivered by Mr. Henry C. Meadow, Associate Dean of the Medical School. The main speaker of the evening was Mr. Henry Alexander, Chairman of the Board of J. P. Morgan & Company, Inc., who spoke on the state of the economy.

LETTERS

Need Piano, Will Transport

The Harvard Medical Chorus needs a used piano in reasonable repair. We will look at any piano in the vicinity which can be properly tuned and will cheerfully transport it to our rehearsal hall.

Contact: Dr. James C. Walker
Peter Bent Brigham Hospital
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Veiled Condemnation?

To the Editor of the *Bulletin:*

To those of us "beyond the pale" of the Longwood Quadrangle and Shattuck Street, your Editorial in the last issue of the *Harvard Medical Alumni Bulletin* raises doubts, uncertainties, and fears. It was too vague; too general; or was it supposed to be? The implication was there: that current medical curricular changes might well lessen the closeness of student-professor contact that has heretofore existed in the preclinical years. If this was what was meant, it was too well couched, and for that reason leaves this Alumnus uncertain and admittedly a bit fearful.

I wonder if other Alumni feel the same way.

Cyrus Stone, '90

Edinburgh Club

To the Editor of the *Bulletin*

Visitors to this side of the Atlantic may be interested to hear of the formation of a *Harvard Club of Scotland.* It is hoped that this will form a channel for providing some hospitality for visitors from Harvard and in providing information for anyone intending to come over for post-graduate work. Membership is open to anyone who has been a bonafide student at Harvard (or Radcliffe). The club is linked with the large and thriving Harvard Club of London and hopes to establish some contact with the clubs of Brussels, Paris and Berlin. The secretary is V. S. MacKinnon of the Department of Constitutional Law, Old College, Edinburgh.

E. Geoffrey Walsh, '46
Department of Physiology
University of Edinburgh

Paranoid Personality?

To the Editor of the *Bulletin:*

Your middle spread of photographs in the *Harvard Medical Alumni Bulletin* of October, 1958 was most pleasing to me, a member of the non-medical laity, and shows that your *Bulletin* is certainly not artistically confined to *materia medica.*

But wouldn't the title of this spread "Doctors Afloat" be more appropriately "Doctors at Sea," for, so frequently, that seems to be the case with your medical profession?

Sincerely yours,
J.K.L.

Editor's note: *A snide remark from an obviously paranoid personality.*

Cramp Rynges and Thaumaturgical Notes

George A. Talland, Ph.D.

Research Associate in Psychology, Harvard Medical School; Associate Psychologist Massachusetts General Hospital

Touching for the King's Evil, as Dr. Goldwyn recently (July, 1958) reminded the readers of the *Bulletin,* was a therapeutic, or at any rate thaumaturgic, function shared primarily by the kings of France and England. The sovereigns of England, however, performed yet another solidly attested healing function: the blessing of cramp rings.*

Originally, the rings were intended to remedy the specific complaints of cramps, convulsions and epileptic attacks which were also known as *morbus Sancti Joannis.* If in time the curative powers of cramp rings became less disease-specific than those of the Royal Touch, the credit must go to such enthusiastic experimenters as Lady Lisle who in the reign of Henry VIII applied the rings of her vast collection to relieve everything from the pains of childbirth to her own rheumatic aches.

Since cramp rings were probably plain gold bands, neither made from exotic material nor carrying magic images and inscriptions, their curative effect was derived entirely from the royal consecration. As in the case of the King's Touch, it became a matter of dispute whether the healing power thus invested in these rings derived from a saintly ancestor of the reigning monarch or from the divine authority inherent in sovereignty itself. In France, attempts were made to trace evidence of the Royal Touch back to Merovingian times (481-751), but Marc Bloch, the eminent French historian and greatest authority on thaumaturgy, disputed these claims and maintained that the first reliable record of royal healing dates back only as far as Robert the Pious (996-1031).

In England, tradition traced both rituals to St. Edward the Confessor (1042-1066). Historians, however, give later dates; Waterton found the earliest mention of cramp rings in the reign of Edward II (1307-1327), and Bloch agreed with him, suggesting that the king may himself have traced back the custom to the Confessor. The second Edward was unpopular from the beginning of his reign and possibly for this reason was not very successful with the Touch. He was badly in need of a successful thaumaturgic record to bolster his shaky authority. This unfortunate Plantagenet was noted for his devotion to the Confessor and, as a result, the belief somehow grew up that the original cramp ring had been brought to St. Edward from the Holy Land, had been buried with him and had caused many miraculous cures at his shrine. From this came the belief that the kings of England had consecrated cramp rings on Good Friday since the time of the Confessor.

In reality, however, the royal custom of blessing cramp rings lasted at most for only two and a half centuries. A special ceremony for the consecration of cramp rings on Good Friday was drawn up under Queen Mary (1553-1558), but she was also the last sovereign to perform it. Both her father and grandfather had blessed cramp rings, and the breach with Rome under her father, Henry VIII, had not interfered with the custom. It appears to have continued under Mary's immediate predecessor, the young Edward VI (1547-1553), but, together with other idolatrous usages, was attacked by Protestant preachers and never revived by Elizabeth or the Stuarts.

There were at all times medicinal rings applicable for other ailments, but into these the Royal Touch could infuse no magic power, and

Though none of the authorities have been able to identify a specimen with certainty, it is generally thought that royal cramp rings were plain hoops of gold, possibly of silver, and were worn on the hand. Jones illustrates his book with two examples, one of silver, and the other of lead, but these are not necessarily of the royally consecrated kind.

the sovereigns of England were as dependent on their inherent healing properties as any other mortal. For example, hardly had the custom of royal consecration of cramp rings been discontinued than Lord Chancellor Hatton wrote to Sir Thomas Smith: "I am likewise bold to recommend my most humble duty to our dear mistress (Queen Elizabeth, 1558-1603) by this LETTER and RING, which hath the virtue to expell infectious airs, and is *to be worn between the sweet duggs,* the chaste nest of pure constancy. I trust, sir, when the true virtue is known, it shall not be refused for the value."

Cramp-ring therapy had one advantage over the Royal Touch — it could be done by mail! There is, for instance, a letter extant to the Lord Chancellor from Lord Berners, Henry VIII's ambassador to the Emperor Charles in Spain, asking for a consignment of cramp rings; and another from Anne Boleyn to Bishop Gardiner in Rome written as an accompaniment to a gift of several cramp rings. Cramp rings also formed part of bequests, as in a will drawn up in the reign of Henry VIII, which lists a "gold ryng with a turkes (turquoise) and a crampe ryng of gold."

Elizabeth's successor, James I (1603-1625), though eager to proclaim the divine origin of his authority, did not revive the usage of blessing cramp rings. No doubt his Calvinist upbringing was responsible for his disapproval of this superstitious practice. Still, a belief in the healing power of cramp rings had pre-dated the custom of royal blessing and, in spite of this royal neglect, it lasted long after Tudor times. Rings were long in common use in England for the cure of convulsions and fits, the only stipulation being that the rings be formed of silver collected at the Communion, and preferably on Easter Sunday. The chronicle of these various other healing rings, however, is a study in itself. The royal rings form but a section of the chapter on cramp rings, and that may not have been concluded yet. Jones quotes an instance which occurred in England in his own time (the end of the last century), "where young men of a parish each subscribed a crooked sixpence to be moulded into a ring for a young woman afflicted with that malady" — the fits.

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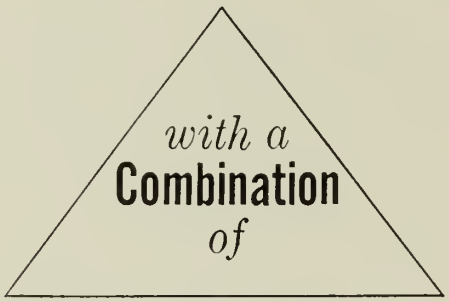

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HARVARD MEDICAL ALUMNI BULLETIN

VOL. 33 FEBRUARY 1959 NO. 2

The Cover: A Japanese brush-and-ink study of birds in motion resembles a photo-micrograph of aortic tissue. This theme is continued on pp. 25-28. "Études d'Oiseaux" is from *Le Japon Artistique,* Vol. II, Paris, 1908. Photomicrographs of tissue cultures of human aortic cells show the effects of different fatty deposits; for research conducted by David D. Rutstein, M.D., Professor of Preventive Medicine at H.M.S.

Along the Perimeter

Dr. Dunphy Leaves

J. Englebert Dunphy, '33, has accepted appointment at the University of Oregon Medical School as Professor and Head of the Department of Surgery. Dr. Dunphy has been Professor of Surgery at H.M.S. and Director of the Harvard Surgical Unit and the Sears Surgical Laboratory at Boston City Hospital since their establishment in 1955. Previously, he was Surgeon at the Peter Bent Brigham Hospital, and a member of the Harvard Faculty of Medicine since his graduation in 1933.

"The University of Oregon Medical School was founded in 1887," Dr. Dunphy said, "and has grown slowly and securely. In the past five or six years a full-time professional staff with adequate research facilities has developed and ground is now being broken for a new research building. There are about 75 students in each class, and this size provides excellent opportunity to develop in the small group the student-professor relationships that have proved so successful at Harvard." He said he plans to introduce a program which will place equal emphasis on teaching, research and patient care, a program well known at Harvard as the "indivisible triad."

In many ways, Bert Dunphy will not really be departing from the New England for which he has confessed devotion and to which he owes his surgical training. After all, he is to live in a community that owes its origins to New England stock and New England custom. He has also clearly stated that he is taking with him the principles of Harvard Medical training. Finally, we shall see him "at the meetings." His travelust will bring him back to Boston for frequent visits; and, by virtue of his new position as Western Representative on the HMAB Editorial Board, *Bulletin* readers may still absorb and profit by that almost classical Dunphy wit and wisdom.

The Phippen Wing

Salem Hospital proudly announced on September 27 the opening of its newest addition, the "Walter Gray Phippen Building." In voting to name this addition for Dr. Walter Gray Phippen, '04, the Board of Trustees honored the man who for more than half a century has always wanted and worked for the best in medical facilities for the Salem Hospital and its community.

Dr. Phippen began his surgical career in Salem in 1907 after internship at Massachusetts General Hospital and further study in Europe. He was a valued surgeon, physician and teacher to Salem Hospital and president of its staff from 1935 to 1953. It was through Dr. Phippen's efforts that Salem acquired the affiliation with M.G.H., which sends a resident to Salem Hospital Surgical and Medical Services every three months.

Throughout his career he took an active hand in the periodic additions to Salem Hospital, beginning with the reconstruction of the Hospital after the great Salem fire of 1914. "Many a time," the *Salem Sunday Express* wrote, "his office had to relay calls to him in the contractor's shack. . . . During such periods of reconstruction, it was discovered that he had an unusual flair for blueprints."

The *New England Journal of Medicine* added recently that to the medical community at large "surgery is simply the neutral background from which Walter Gray Phippen has periodically emerged — to become president of the Massachusetts Medical Society from 1939 to 1941, and president of the Boston Medical Library from 1946 to 1952." The Journal commended especially his work on behalf of the Library. We would add that he was president of the New England Surgical Society from 1942-1944.

All Dr. Phippen's friends and colleagues — especially those at H.M.S. — are delighted to know of this well-deserved tribute.

The *Bulletin* continues here its series dealing with the School's professors, hoping to give the Alumni a nostalgic glimpse of the men who contributed to their development.

*Anolis Bremeri**

Forty classes can remember the meticulous anatomy professor who, from his graduation in 1901, until his retirement as Hersey Professor of Anatomy in 1942, combined German clarity with Boston dispassion in his lectures. His father was a Philadelphian of German descent, and his mother a Boston Farnsworth. One former student remembered: "He was always so impeccably dressed, nothing would have pleased me more than to see him appear before the class with one button open." — He never did.

He grew up, first on the Hill at 49 Beacon Street, and later, on the "water" side of Beacon, in the days of carriages and many-course dinners, when behind the fashionable Beacon Street homes, servants' quarters overlooked the Charles, as did the rats.

In this era of gentle aristocracy, Dr. Bremer was a gay and debonaire Harvard undergraduate, captain of the track team in his senior year and, though few people are aware of it, Intercollegiate Champion for the 220-yard low hurdles in 1896. His record stood for several years.

He spent a year between Harvard College and Medical School in England, boning up on the "stinks," as the English referred to chemistry. Chemistry, he says, was less important in this English experience than the warm professional and personal friendships formed, which have continued throughout his life.

With semester-end in February, 1897, the "stinks" were forgotten, as Dr. Bremer with an English friend set off to cross Siberia. The Trans-Siberian Railroad was being built and the party was often forced to disentrain and ride horseback for long stretches. Bremer carried a rifle and ammunition throughout the trip. He was en route to fulfill his fondest hope: to shoot a black panther in the Orient. But the friend living near Singapore who had promised him good hunting unfortunately died before Bremer arrived: The natives had taken a dislike to him and put ground glass in his eggs.

*The late Professor Thomas Barbour, Curator of the Agassiz Museum at Harvard, was Dr. Bremer's frequent traveling companion and good friend. Together in Cuba, they discovered a new species of lizard, which Dr. Barbour named after Dr. Bremer, *anolis bremeri*.

Dr. Bremer, '01

"I have always avoided dangerous travel," Dr. Bremer says, "and enjoyed calm and leisurely trips." When a friend asked incredulously if wading ankle-deep in bat dung through Cuban caves in search of embryological specimens fitted this description, he replied, "Oh surely, we always took a stout string, letting it out as we went along, and we never got lost."

True to her husband's concept of travel, Mrs. Bremer and Mrs. Thomas Barbour on this occasion passed the time by playing cards on a flat rock by the mouth of the cave. When the Cuban guide accompanying them suddenly began brandishing his machete belligerently, the ladies assuaged him by photographing him innumerable times, "even long after the film was run out."

Combining travel in vacations with his embryologic investigations, Dr. Bremer feels, has been a great source of satisfaction. His mentor, Dr. Charles Sedgewick Minot, asked him to stay on at the Medical School after graduation in 1901, as instructor in histology, and help assemble a comprehensive embryological collection of mammals for the Anatomy Department. Central America, the Caribbean, and Florida have furnished him with specimens for this collection. Once at a loss to procure opossum embryos for his research, Dr. Bremer even made a trip to South Carolina to trap his own specimens. "When the baby opossum is born, it is only about half an inch long, but it must be able to breathe air. It's a wonderful example of embryology in the open. They're very easy to handle: I'd catch them in the evenings and carry them home by their tails."

Why did Dr. Bremer choose embryology? "When I'd gone to Medical School, I knew I didn't want to become a physician." A friend adds: "He always told me he hated obstetrics most; especially delivering babies in South Boston at 3 A.M." "Embryology is a neat, clean science, and I liked it," Dr. Bremer says. "When I came upon something I didn't understand, I began to study it. When certain things were strange, I wanted to see why."

This durable curiosity has led, after retirement from H.M.S., to a continuation of research in a laboratory provided for his use at Children's Hospital in Boston. At 83, Dr. Bremer has recently seen the publication of a new book, the result of his investigations, entitled *Congenital Anomalies of the Viscera.* A colleague terms this book a " 'knockout,' " adding, "It should certainly be read by every surgeon interested in the correction of congenital defects."

Of his standard *Text-Book of Histology,* Dr. Bremer says: "This was originally a German book by Stöhr. Dr. Frederic T. Lewis of our Anatomy Department translated it, and after

seeing it through one or two revisions, I took it over. I've completed several editions myself; the most recent revision was made by the late Dr. Harold Weatherford in 1944. I doubt if anything now remains of the original Stöhr."

This might be one means of avoiding the crush of modern medical literature. Dr. Bremer hasn't ventured an opinion on this subject: The man who made a major contribution to physicians' awareness of congenital origin of abnormalities was never an outspoken person. He has contributed very quietly. But he has mentioned that he is saddened by the dearth of embryological teaching going on today.

"Unassuming curiosity, shyness, reserve, gentility, and deep loyalty": these are the qualities friends add to that of professional excellence. And we may assume that Dr. Bremer is all of these things, whether teaching, conducting research, or when walking along the bottom of the Panama Canal. "Of course," he adds imperturbably, "the Canal was empty."

Harvard Medical Chorus

The Harvard Medical Chorus came into being in September, 1958. Membership was encouraged for anyone in the Harvard Medical community who liked to sing. Seventy to eighty people appeared by the third Tuesday evening rehearsal, and the initial possibility of a chorus became a reality. Members included students and Faculty of the Harvard Medical School, School of Public Health and School of Dental Medicine, and doctors and employees at the various Boston hospitals affiliated with the University.

Rehearsals were at first held in the nurses' amphitheater at the Brigham Hospital, but were soon transferred to the more congenial and atmospheric surroundings of the Boston Lying-In basement auditorium. Financial assistance for a piano was scratched together from here and there. The tuner wouldn't touch the antique and somewhat temperamental p i a n o but the chorus, having no alternative, continues to use it.

The Chorus has two conductors, Phyllis T. Bodel, '58, Interne at Boston City Hospital, and Dr. James E. C. Walker, Assistant in Medicine at the Brigham; and an

David Lawlor

The new Harvard Medical Chorus sang in Vanderbilt Hall on December 30.

accompanist, Richard M. Friedberg, '60. Dr. Walker transposed the idea for a medical community chorus from his previous acquaintance with the Wisconsin Medichoir, a singing group at the Medical School of the University of Wisconsin. His enthusiasm for conducting came from his leadership of several small choirs in Korea and Japan while in the army. Dr. Bodel, who sang with the Radcliffe Choral Society under G. Wallace Woodworth, took "Woody's" summer school course this year in the fundamentals of choral conducting, and was eager to help in the musical enterprise. The advice and support of Professor Elliot Forbes, the new conductor of the Harvard and Radcliffe choruses, was of great assistance in making final plans.

The Harvard Medical Chorus presented its first concert of Christmas music on December 19 in the Jimmy Fund Auditorium. The program included selections by Bach, Palestrina, Brahms, and Mozart, and the short concert was warmly received by the audience. On December 30, the Chorus sang again at the Dean's Christmas Party in Vanderbilt Hall.

The association of the Chorus with the Harvard Medical Community does not alter its thoroughly amateur quality, but to boast membership ranging from orderlies to well-known surgeons does provide a certain measure of distinction. The enthusiastic response of singers, friends and audiences seems to promise a bright future for the new year, and hopefully for more to come.

David Lawlor

Foreign doctors were entertained at Harvard Faculty Wives' Tea. (Left to right) Mrs. Charles Lund; Dr. Karlini Rohtiatmo, pediatrician from the University of Indonesia medical faculty; Dr. Norimasa Hosoya, biochemist from Tokyo Women's Medical College. They are visiting, respectively, The Children's Medical Center and the Boston Lying-In Hospital.

Foreign Doctors

In our readership survey, made in 1956, our Alumni asked frequently to hear about foreign doctors in Boston.

The Medical School itself has between 90 and 100 foreign doctors every year. The great growth in this program has occurred since 1940. Across the street at the Brigham, there are 58 foreign doctors and these are primarily engaged in research. The largest contingents come from England and Switzerland.

Beth Israel Hospital presently has thirty foreigners, of whom three are in research. Some come for only a short period of time but many for several years. Dr. Joseph Oren recently returned to Israel after 2½ years of study of the early mother-child relationship, to become Director of Child Psychiatry at Hadassah Hospital in Jerusalem.

Children's Hospital has 54 foreign doctors of whom one third are engaged in research studies. Both Children's and Beth Israel have more Canadians than any other nationality.

Boston City Hospital has about 100 foreign doctors — from every country except Communist China and Russia. 98% onwards are participating in active care of the patient, with very few engaged in research work. Most come for a year's stay in conjunction with the State Department Exchange Training Program and they may renew their visa yearly for up to five years. The greatest number do stay five years. After this, they may apply for immigration on their regular quota. Since 1956, however, foreign doctors have been duty-bound to return to their homelands for two years before they request to return to the United States.

The great increase in the foreign doctor exchange program at Boston City Hospital has been since the Korean War. Ten years ago, it didn't even exist. Lately, the number has leveled off and the new American Medical Qualification Examination, which has replaced the list of approved foreign medical

schools may make a dent in the number who come.

Dr. James V. Sacchetti, Assistant Superintendent at Boston City Hospital, said that foreign doctors adjust, speak and write English well, are interested in what the hospital has to offer and are accepted completely by their colleagues. "My point of view is not accepted universally," he said, "but I believe that when these people see our way of thinking and doing things they will go to their countries, and their arguments against antagonistic ideologies will be more effective than millions of words of rebuttal."

M.G.H. has 150 research and clinical fellows who come for periods of a few days, weeks or 2-3 years, from 50 different countries. They are greatly helped by the M.G.H. Reception Center, run by the Staff Wives Association, which keeps a housing file and helps the foreign doctors and their families find apartments. The Reception Center also has a furniture exchange because it is easier to find unfurnished than furnished apartments. The furniture is stored at McLean Hospital in Waverley and transported by hospital truck. At any one time, there are about 50 families using this furniture. The Reception Center helps in finding schools, buying cars, explaining the legal aspects of signing a lease. It sends out a brochure ahead of time telling about climate and clothes, explaining that the servant situation is very different from, for instance, South America or South Africa.

Dr. Hale

Many Alumni will remember Dr. Worth Hale with affection. The Alumni Office had a Christmas card from Dr. and Mrs. Hale. They are living on Silver Street in Monson, Massachusetts, about fifteen miles from Springfield. They would enjoy hearing from Alumni and receiving a visit from anyone passing through or near Monson.

Beth Israel Celebrates

Shortly after the dedication ceremonies in 1928 the Beth Israel Hospital admitted its first patient to a new building on Brookline Avenue. On December 7, 1958, the hospital celebrated the 30th anniversary of this occasion at a dinner in the Hotel Somerset.

Many B. I. celebrations have preceded the present one. In 1916 a mortgage-burning ceremony was held when the original building that housed the Beth Israel was paid for. An enthusiastic throng gathered at the bonfire to purchase bits of the mortgage to burn. When the smoke cleared away the auctioneer reported a surplus of over $6,000. The Beth Israel first opened the doors of a 45-bed hospital to patients at this original site on Townsend Street in Roxbury on February 14, 1917, just two months and two days before the United States declared war on Germany.

In 1927 a Victory Dinner was held in honor of the purchase of land on Brookline Avenue and the beginning of construction. In August, 1928, a third great celebration took place amidst pomp and ceremony: the dedication of the new building. Its teaching affiliation with H.M.S. began almost simultaneously and for a quarter of a century the B. I. was the only Jewish sponsored hospital in the United States to attain the full rank of a university teaching hospital.

At the 1958 Thirtieth Anniversary Dinner, the Beth Israel looked back on its accomplishments of those 30 years. When Dr. Herrman L. Blumgart, '21, received a citation at the dinner, he personified the growth of the Beth Israel. Coming in 1928 from the Thorndike Laboratory at Boston City Hospital, Dr. Blumgart can remember beginning cardiovascular research in two rooms in a cellar, with Dr. Samuel L. Gargill, Dr. A. Carlton Ernstene and Mrs. Dorothy Gilligan as the other members of the team. Helping the Beth Israel expand to become one of the leading hospitals in the Nation, in the tradition of the university triad, he has himself become the first full-time professor of medicine in a Jewish hospital and is now Physician-in-Chief at the B. I.

The educational programs and affiliations of the Beth Israel include Harvard and Tufts Medical Schools, Boston University School of Nursing and Simmons. The increasing financial support from agencies which grant funds is a good measure of the quality of work done by the research staff. The Beth Israel has given two million days of care to 200,000 people in the Boston area and has served patients from every section of the United States as well as foreign countries. In addition, its Home Care program, which now stretches 15 miles in all directions, is able to give good care for as little as $3.00 a day to home patients. The Hospital has due reason to celebrate.

New Appointments

Dr. Jack Richard Ewalt, Commissioner of Mental Health in Massachusetts and Clinical Professor of Psychiatry at Harvard, has been named Professor of Psychiatry to serve simultaneously the Massachusetts Mental Health Center as Director and the Harvard Medical School as Professor.

In his post at the Harvard Medical School and at the Massachusetts Mental Health Center (formerly the Boston Psychopathic Hospital) Dr. Ewalt succeeds Dr. Harry C. Solomon, '14, Professor of Psychiatry, *Emeritus*. Dr. Solomon, in turn, has been appointed to Dr. Ewalt's post as Commissioner of Mental Hygiene.

Since coming to Massachusetts in 1951 to head the Commonwealth's mental health program, Dr. Ewalt has worked closely with Dr. Solomon to strengthen clinical, research and teaching activities at the Mental Health Center.

The Harvard Medical Library

THE PROBLEM AND THE PLAN

C. Sidney Burwell, '19

Samuel A. Levine Professor of Medicine

Chairman Of The Harvard Medical Library Committee

In libraries, as in other human institutions, the most important assets are not material ones, such as buildings, books, or even money, but people. For many years the Boston Medical Library has been fortunate in the people who have directed its objectives and participated in its administration and operation. It has never been more fortunate than in the years in which its president was Dr. Arthur W. Allen. He applied his clear vision, his energy, and his wisdom to understanding the problems of the Library and to the patient planning for its future support. All of us think of him with affectionate admiration and with gratitude for what he did for the Boston Medical Library.

Dr. Allen had a deep interest in the Boston Medical Library for itself and as a part of the total medical library facilities of the Boston and New England community. For a number of years I have been the Chairman of a Committee charged with the reorganization of the library serving the Harvard Medical School, School of Public Health, and School of Dental Medicine. With this responsibility I, too, have been thinking about the total medical library resources of the community, and Dr. Allen and I have discussed and explored this matter on several occasions. It was his suggestion that I present to you tonight a brief summary of what our studies in recent years have taught us about the definition of the Harvard Medical Library problem and about the plans that are now being made for the future of that Library as a library serving the Harvard Medical area and the general medical community.

My own experience with the administration of medical school libraries began in 1925 when G. Canby Robinson made me a member of the Library Committee of the Vanderbilt University Medical School at the time of the School's reorganization. Our Committee had the advantages of the leadership of Dr. and Mrs. Robert S. Cunningham, and also of the low prices for books which existed before and after the famous depression of 1929. The result was that by the early thirties there was an extraordinarily effective library. It had fewer than 50,000 volumes but they were 50,000 hand-picked volumes, with a minimum of inactive material and a maximum of useful and complete sets. This taught me that the measure of a library is its utility and not its size.

Separate Functions and Cooperation

A general principle may now be enunciated — namely, that there is no reason why all medical libraries should be alike or should aim at serving identical functions. A similar generalization is quite applicable to medical schools and to hospitals. It is wasteful and uneconomic for all the hospitals in a community to equip themselves to do everything. Diversity is stimulating as well as efficient, and is one of the situations which lead to creative and original planning. Many hymns have been sung in praise of diversity — one by a modern poet is at once profound and gay. Mrs. Phyllis McGinley in a Phi Beta Kappa poem read at Columbia Commencement a few years ago included the following lines:

> "Rejoice that under cloud and star
> The planet's more than Maine or Texas
> Bless the delightful fact there are
> Twelve months, nine muses, and two sexes;"

If the principle of diversity is adopted among a group of libraries in a community, then the principle of cooperation should also be applied among the same libraries. If the two principles of diversity and cooperation are adopted, there is then a duty for each library to analyze and define specifically the scope of its collection and of its collection program, and to be ready to play a part which makes it a functioning member of the general library community.

Since this word is central to this discussion let me discuss briefly what I mean by cooperation among medical libraries. This should be done in the light of a few facts about the present situation of medicine and medical publications. The second edition of the *World Medical Periodicals** published by the World Health Organization appeared two months ago. It lists 4,772 separate journals. Even so it is short of the

Dr. Burwell reviews the changes in the Library's function during the last three decades and outlines plans for an adequate reorganization. This article was originally presented on April 1, 1958 as the Annual Discourse to the Fellows of the Boston Medical Library.

**1957, published by World Medical Association.*

mark: this list is made up of *medical* publications specifically and does not include many varieties of other essential material, such as physics, chemistry, mathematics, sociology and history. I daresay that with the medical problems of outer space just around the corner, medical libraries may soon have to have sections on astronomy. This will not be an innovation since the role of the stars in medicine is an old one; only the emphasis will be different.

The great increase in the subject matter of medicine, in the number of journals and in their specialization is, I am afraid, leading to a sort of isolationism among specialty groups. The trends in American education seem to me also to have led away from effective knowledge of foreign languages on the part of our young people. The new illiteracy which has come about is so widely recognized that it is sometimes cited as a reason not to subscribe to foreign language journals for medical libraries. At a time when medical education and medical research are developing in countries all over the world, it is vitally important that their literature should be well represented in our medical collections.

The case for cooperation is simple: no single library can hope to cover the field, while a number of them can, by working together, increase the assets of all. The next question is: can a group of independent libraries, each with its own problems, collaborate effectively? My answer is that this is entirely practical if certain general rules are followed.

The first of these is that each of the independent libraries maintain its independence. Cooperation and collaboration must be voluntary. Each independent library must define its own functions and make specific plans to meet its own specific obligations.

Second, every medical library in the community must have a basic collection with which to serve its constituents. Therefore, some *planned* duplication is inevitable and necessary. But *sharing* in the use of less-used material is quite practical and could, if suitably organized, enable every medical library in the community to enjoy greatly expanded available assets.

Let me present an example of planned duplication and planned specialization. Every medical library in Boston will have to have the *Journal of Clinical Investigation,* the *American Journal of Physiology,* and the *New England Journal of Medicine.* If *one* library had the *Archiv. für Entwicklungsmechanik der Organismen,* it would suffice for all if these volumes were promptly and easily available. This is to say that some kinds of material are appropriate for sharing and some kinds of material are necessarily in each library.

Plans for the Future

The last reorganization of the Harvard Medical Library was made in the late twenties, and since then no effective reorganization has been made. It is long overdue. In planning for reorganization we now have the inestimable advantage of a new experienced librarian, Mr. Ralph Esterquest, who arrived recently from Chicago where he organized and was head of the Midwest Inter-Library Center. This Center opened in 1949 and now serves 18 midwestern universities through inter-library loan and through the storage of little-used materials. Each university would find it hard to justify the expense of these materials for itself but under a cooperative plan the cost of acquiring and servicing can be shared. Thus, Mr. Esterquest is particularly aware of the problems of acquisition and storage which I mentioned earlier, and he is particularly familiar with current concepts in inter-library cooperation.

The establishment of such a league of cooperation among the medical libraries of Boston need not in any degree limit the freedom of any individual library. Inter-library cooperation makes voluntary restriction a practical matter since this restriction would be planned in relation to the other collections.

It is not necessary to emphasize the changes in medicine and medical education: the advances of medical science; the bringing together of science and practice, the expansion of the medical spectrum to include the physical and social sciences; the prolongation of medical education; the development of the residency system; the progressively closer relationship between university and teaching hospitals; the increasing importance of public health; the alteration in the character of the School of Dental Medicine; all make necessary a new definition of the function and needs of the library.

In the last thirty years, also, the clientele of the Library has changed: there are more medical students; there are fewer dental students, but more use the Library; there are more public health students; many more candidates for the Ph.D. degree in the Medical Sciences; and there are more people taking postgraduate courses. There has been, at the same time, an almost astronomical increase in the size of the teaching staff in all Harvard departments. In 1958 the Catalog of the Medical School lists 1552 names holding appointments. Dr. Reginald Fitz was a continuous and careful student of the history of this Library. He told me that in the late twenties when the Library was last reorganized there may have been a dozen or two Research Fellows in the various departments of the three Schools in the medical area. Today, there are between four and five hundred Research Fellows, and these create a demand on the Library which is quite possibly greater than the *total* demand of thirty years ago. Most of those in this room can remember the explosive expansion of the residency training programs in the hospitals associated with the Harvard Medical School, Dental School and School of Public

Health, and can imagine the increase in the number of men and women in this category who are to be considered as important and significant graduate students and who use the Library.

It is pretty obvious, therefore, that reorganization and enlargement of the Library facilities are urgently needed. The committee charged with this responsibility has set up certain general principles which, in their opinion, should apply:

1. The reorganization should be planned to serve the needs of the special community for which it is designed.
2. It should be planned to serve these needs for several decades.
3. Every advantage should be taken of modern techniques of library management. These include a number of methods which up to now have not been used to a sufficient extent. Some examples are: inexpensive techniques for storing little-used items; the use of modern copying methods; and a staff familiar with the modern reference complexities.

An even more important technique, in our opinion and hope, is increased cooperation among the libraries of Boston. To my mind this implies an expanded messenger service.*

The Harvard Medical School, Schools of Dental Medicine and Public Health are all closely associated with various hospitals, dental infirmaries, and public health organizations. Departments of these Schools are actually located in such institutions. One of the objectives of the reorganization is to serve better the University personnel of these departments. Availability should be the watchword in this cooperative enterprise: machinery should provide that books be made available promptly to the scholar, *wherever in the community they may be* and, at the same time, adequate duplication and copying services should be provided for much used materials.

In recent decades the concept of the storage library has been developed. Here, seldom-used books can be stored for about a quarter of the cost of keeping them on the shelves of an active library, yet can be drawn on twenty-four or forty-eight hours' notice. Proper use of the storage library not only reduces pressure in the central library, but also makes the central collection easier to use. We would certainly propose to use this principle in our reorganization, and we hope that further units of this extraordinarily useful type of building will be constructed.

Summary

With these concepts in mind, the work of the Library Committee, with the advice of the University Library officers, has developed the following goals for the new Medical Library:

1. A book capacity of about twice the present one.
2. An increase in reader capacity from the present one of about 250 readers to at least 750.
3. A library staff at least twice the size of the present staff.
4. An annual budget of approximately three times the present one.

It appears that, to accomplish these objectives, one of the essentials is a new building. To build and to equip a library of the general magnitude and type required, and to supply capital for its operating budget, new resources of approximately seven to eight million dollars are required. Dean Berry tells me that these funds will be found.

We have taken the first and most important step toward planning the Library in finding our leader in Mr. Esterquest. We are, therefore, now in a position to make plans for the future, plans by which we intend to accomplish two important tasks. First, improved library service to the teaching and research groups in the medical areas of Harvard, and facilities which will serve as a unifying influence binding together the diverse units that make up these three schools.

Second, a development which will add to the available pool of medical literature in the Boston community. It is not too much to say that if we can achieve a common-sense cooperation among the medical libraries in Boston, if good communications and understanding can be established and maintained among them, then this group of libraries may collectively become a medical library facility appropriate to the high position of Boston as a world medical center.

One of the pieces of machinery that might be useful in such a cooperative organization is an accurate and up-to-date Union Catalog. Since the late thirties this has been approximated as regards their two collections by the Boston Medical Library and the Harvard Medical Library. It should, in my judgment, soon be extended to include the Library of the Tufts University School of Medicine and that of Boston University School of Medicine, at least as concerns journal holdings. Perhaps one of the cooperating libraries should be designated as the information center where immediate information could be obtained as to the location of given items. It seems to me that the Boston Medical Library might well be the logical place for this information center since it holds a central and established position among our medical libraries. It could thus act as the coordinator of the library resources of the community.

One question might be asked: is all of this idea of cooperation unnecessary? Is the development of a National Medical Library in Washington going to

(Continued on page 36)

**Mr. Esterquest reports that this expansion is already going on.*

Editorial

CONTINUING SURGICAL EDUCATION IN THE COMMUNITY HOSPITAL AND THE ROLE OF THE DOG LABORATORY

The provision of optimum medical care for the patient in his "home community" requires the solution of certain clearcut problems. Our medical schools must take an active lead in finding practical answers. First, the practitioner must be aided in his desire to maintain and expand his professional competence under the stress of active practice; second, help must be given to the community hospital to attract interns and residents. These young people expect this part of their lives to be a continuation of their medical education and gravitate toward the "teaching hospitals" despite the fact that many of the community hospitals have able physicians and surgeons who enjoy the stimulus of teaching, and residency programs offering greater opportunity for personal experience, greater responsibility and greater satisfaction for service than some of the university centers. The continuing education of the senior staff in these community hospitals bears a close relationship to the ability of such hospitals to attract able young house officers.

Medical school curricula today foster the triad of teaching, research and patient care — the essentials of good medicine. Standards of routine care would decline [even in this optimum setting] without the stimulus of teaching and investigation. To this end the students, interns, residents and faculty are encouraged to participate in research, — at least until they leave for the community hospital. Should there be such an abrupt transition? Should we foster double standards?

The educated surgeon in this country has been expected to perfect his surgical knowledge and skill by working in the experimental laboratory. The importance of the dog laboratory was stressed by Harvey Cushing, who felt that the decline in productivity of the British hospitals since the time of John Hunter was no doubt the result of the curtailment of animal experimentation. Now, with the increase in the number of people covered by surgical insurance, and the consequent decline in the surgical ward population, will not the "dog lab" assume greater importance in the continuing education of the knowledgeable and skillful surgeon?

The stimulus for this editorial came, in part, from a letter written by a Harvard Medical School graduate who recently completed his surgical residency in the Harvard Medical Center and departed for his home community to practice surgery and to help run the internship training program. As a good product of the Harvard environment the thing he missed most, he wrote, "was proximity to a laboratory, — both as an integral part of the internship education program, and for my own research. And yet, there was considerable opposition to my setting up the laboratory despite the fact that several years ago I was running such a laboratory in Boston. Fortunately, we have an enlightened staff and board of trustees who became convinced that the establish-

ment of such a laboratory would do nothing but raise the level of medical care in the entire hospital, and make our residency program more attractive."

"Since we have trouble finding enough service patients we decided to give a course in experimental dog surgery rather than use the patients as training ground for the neophyte. What is there so pernicious about learning to suture a bowel in a dog properly cared for and supervised as opposed to subjecting a patient to more prolonged anesthesia when a junior man does his first bowel anastomosis on a human patient? As you probably know, in Korea, when we were faced with large numbers of soldiers with vascular lacerations to be treated by young surgeons, a large animal laboratory was quickly established to give the officers the necessary experience and skill. This was a good step and resulted in the saving of many limbs.

"Now I've started once more on my own research, which makes my present position even more attractive. And this one research project has already led to the revival of a journal club, so that the entire staff immediately benefits. The news is out that we're trying to make our internship a real educational opportunity so now we're getting inquiries from prospective interns who wouldn't have looked at us a few years ago. If only we could work out some sort of affiliation with our alma mater we would feel less isolated, our research would be more fruitful, our patient care better, and the public would be reassured that the standards of animal care were the same as in the medical schools."

A. C. B.

* * *

A MESSAGE
FROM THE DIRECTOR OF THE ALUMNI ASSOCIATION
Progress Report

As Director of Alumni Relations, I submit with great pleasure the following brief progress report. In 1952, in my First Annual Report, I told you that the response from our Alumni rose from about $10,000 to well over $100,000. I also mentioned in this report that I was told that, if in our first year we got as much as $50,000, it would be a very creditable showing indeed.

A somewhat pessimistic individual also told me that, as the H.M.A.A. in the ten-year period prior to 1952 had contributed a total of only $80,000, we should not be too optimistic for the first few years. Well — our Alumni gave over $100,000 the *first* year. We are now at the mid-point of our *eighth* year. And in early December, 1958, the total of unrestricted money coming from Alumni since 1952 passed the one-*million*-dollar mark. Let me emphasize that this is unrestricted money, and does not include the many thousand dollars coming from Alumni for specific purposes. I cannot tell you how much I appreciate the work of our class agents — and the loyal response from our Alumni.

THOMAS H. LANMAN

Norman Fortier

The Aquila

THE BERMUDA RACE

George H. A. Clowes, Jr., '41

The Bermuda Race this year brought together the greatest fleet of fine, well-found ocean racing yachts ever to be assembled for a major deep-water race. Manned by more than 1,000 enthusiastic yachtsmen, 115 vessels started in half a gale off Newport, R. I., at noon on June fourteenth. The long southerly course to Bermuda was to take them 635 miles out into the Atlantic across the often angry Gulf Stream.

I was fortunate enough to sail our yawl *Aquila* in this memorable event with a lusty crew of seven fine fellows. It is my purpose to tell the story from my personal viewpoint in explanation of why men will subject themselves year after year to the hard, tiring work of a long ocean race.

Months, in fact, years of preparation and thought were coming to fulfillment as *Aquila* bore down on the starting line. She is a 42-foot yawl built for us by Tore Holm in Gamleby, Sweden, to the designs of Sparkman and Stephens, Inc., of New York. Since my introduction to the first Revonoc of the late Harvey Conover, I have been impressed with the virtues of the keel centerboard boats. *Aquila* is of this type, and in many respects similar to the famous *Finisterre*. She is rather longer in the ends and of a little more draft, making her more like a conventional keel boat with all the stiffness and broad beam of the centerboarders. The happy result is a comfortable, easily handled vessel with a fair turn of speed.

In 1957 she was finally finished. My wife Peggy and our two oldest children, Mardi and Alec, went with me to Sweden to cruise in her through the lovely Scandinavian waters of the Baltic, Denmark, and the west coast of Sweden. We came to know and trust *Aquila* like a friend whose capabilities became undoubted. Yet this voyage to Bermuda was to be her first race.

We spent weeks making those careful preparations so vital to a race, but still many things remained to be done, when we arrived at Woods Hole a week before the race. Several of the crew were there to help including Dr. Jimmy Jackson, '43A, our second mate: Jim Wickersham, the navigator; Dick Copplestone, our cook, known as the "Major" (he really was one in the British Army); and Ben Williams, strategist and nautical statistician. As the check list dwindled and the stores were put aboard to be stowed, *Aquila* sank deeper in the water until she was nearly three inches below her measured water line. We sailed to Newport Harbor and there the three remaining members of the crew came aboard: Worth Loomis, our first mate; his brother Bob; and Charlie Coles, all able racing sailors.

The race morning dawned bright and clear with a strong north wind blowing. By noon when the large boats of Class A started, it was up to 30 knots, and when we in Class C crossed the line between the Destroyer *Darby* and Brenton Reef Lightship, it was piping a good 35 knots. Many of the boats including *Aquila* started under spinnakers! Seldom have been seen such knockdowns as some of them took under this press of canvas. One of the Navy yawls, *Flirt,* was laid on her beam ends and had to withdraw subsequently with a damaged rudder.

We were not without our own difficulties. Half a minute after starting, as the spinnaker was being trimmed, the block at the masthead parted and the big sail flew out ahead to fall in the water and be dragged under the keel, breaking our spinnaker pole as it did so.

Fortunately, the sail, the lines, and both ends of the pole were salvaged and dragged up over the stern. After setting our largest Genoa jib and the mizzen staysail, work was started to repair the pole. Plywood was sawed into strips to be firmly bound in place as splints. Two hours later when this had been accomplished, Charlie Coles went aloft in a bosun's chair to shackle a new block to the tang at the masthead and reeve the spinnaker halyard. This was an operation in the sea running off Block Island. By the time all this had been completed and the spinnaker had been reset, we were bowling along among the leaders of Class D, which had started 15 minutes behind us. From then on it was a race to catch our own class.

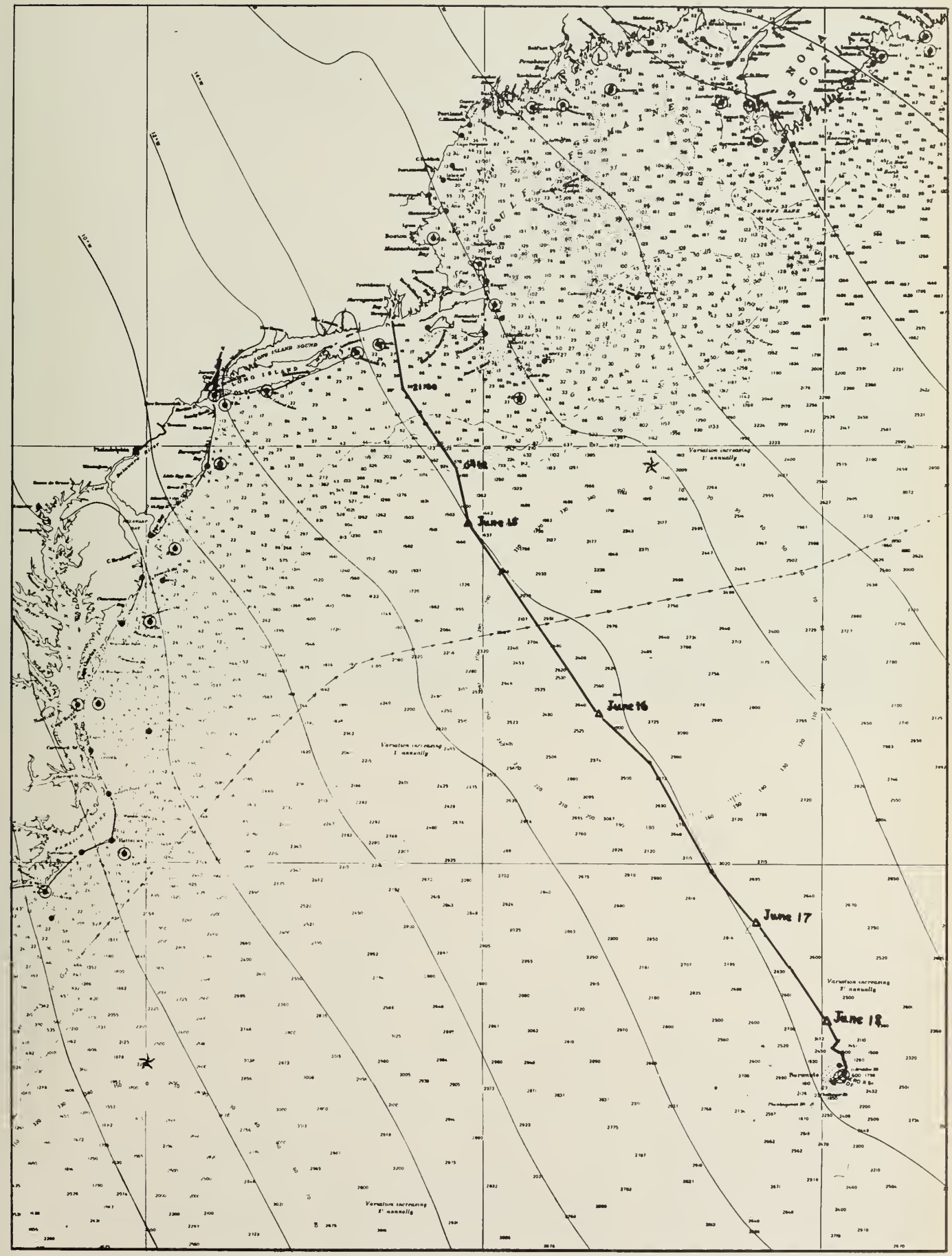
Saturday night the wind moderated and gradually backed into the west. The spinnaker was sheeted more and more abeam. Then, in a puff, the pole touched the headstay and instantly broke again. The plywood just wasn't strong enough. After resetting the large Genoa, we again went to work and built a strong box section, carefully screwed together from planks sawed out of a locker cover. This held until Monday, when for the third time, the pole broke, necessitating its being shortened to get rid of its fragmented center portion. From then on it was known as "stubby."

Fractured spinnaker pole (left center), 18 hours after start of race; Coles left, Wickersham right.

Much to our delight we passed several of the boats in our class Saturday night. Sunday we intermittently carried the spinnaker or jib as the wind came aft or forward. By then, we were well established in the order of four-hour watches, except for the Major and myself, who stood no regular watches. He cooked, when necessary helped with the sailing, and slept when he could. To his credit was due the morale of the ship's company; we never missed a hot meal despite all sorts of conditions of wind and sea.

There had been many sails visible on the horizon, and as the day drew to a close in a beautiful windy sunset, we gradually overtook two yawls. One was *Finisterre*, and the other Ernest Ratsey's *Golliwog*. Then ensued a night-long race. Being slightly larger, we finally passed them, but near two o'clock in the morning Worth Loomis, who was in charge of the port watch, noticed that as the wind moderated and came more out of the northwest, *Finisterre* had set her spinnaker again and was overtaking us in her turn. Soon we had ours drawing again, and, sailing a slightly divergent course, we watched her running lights disappear over our

TRACK CHART OF THE AQUILA →


June 15
June 16
June 17
June 18
Variation increasing 1° annually

port quarter, and we did not see her again until we met in a squall near Bermuda.

Monday dawned bright and clear with a wind which continued to increase gradually through the day. Several vessels were in view, and sails of others well down over the horizon could be seen aft. We hoped these were our competitors of the previous night. To keep the spinnaker drawing, we bore off slightly to the east. Our noon position had shown us to be about 20 miles to the west of the rhumb line. The water temperature had gradually risen to 79°F. from the 62° recorded on Sunday morning. This suggested that we were well into the main current of the Gulf Stream. This was borne out by the deep blue color of the sea and the rows of cumulus clouds which marched continuously down on us from the west. As the wind on the quarter increased, steering became progressively harder, and at times, a second man was needed at the tiller to hold *Aquila's* head off on her southerly course. This was again the result of driving the boat to the limit with a tremendous press of canvas in a strong wind. The Kenyon log was registering speeds over nine knots frequently. As the wind blew harder it backed round more to the west southwest making it virtually impossible to continue to carry the spinnaker. With a last gesture an extra strong puff stretched the after guy enough for the pole to touch the headstay. It broke for the third time. Again the spinnaker was doused and the large Genoa was set with little appreciable loss of speed.

As the sun set, we were still driving hard on a reach with the large Genoa set. An excellent star fix was obtained as different parts of the sky were glimpsed between the hurrying clouds. About midnight, again with the wind farther aft, the spinnaker was reset on the shortened pole and drew well. As we rushed on through the night coasting down the backs of big waves, the wind veered more toward the northeast necessitating a gybe.

By midmorning Tuesday, the wind had fallen to a very light breeze from the northwest. The sky was clear and the sun warm. Shaving and shower baths on deck with buckets of warm Gulf Stream water became popular. About noon, Jim Wickersham came from below to say that he had found our days' run to be 193 miles. Despite the hope of breaking the wonderful mark 200, an average speed of a little over 8 knots was pretty good considering that we had been becalmed for the last two hours.

The afternoon wore on with the wind falling lighter still, yet an extraordinary thing was taking place which made this a race favorable to the smaller boats. The sun sank into a bank of heavy clouds, and as night overtook us, we found ourselves slowly overhauling several boats ahead. At midnight we too were flat becalmed while several lights came up over the horizon astern. Within our visible radius we counted more than fifty lights bobbing about in the dark starry night. About half-past one in the morning, several lights came up from astern but seemed to overtake us with considerable speed. With them came a nice westerly breeze which gradually hauled into the southwest. As morning approached, much to our surprise, we found ourselves sailing along with a long line of much larger vessels all close hauled on the course to Bermuda. Although we were then only sixty odd miles from Bermuda, the radio announced that none of the boats had finished as yet. Evidently the larger vessels had run into the same belt of calm only to be trapped until they caught the same breeze that came to us out of the west. Needless to say, morale was high.

During the morning the wind increased and backed further into the south making it a dead beat to windward. Then ensued an afternoon of vicious squalls blowing from various directions with sheets of rain and calms between. At times the mainsail was reefed with the mizzen stowed, and at others we carried full sail. About five o'clock while driving along at nine knots in a squall blowing from the northwest, we s u d d e n l y saw through a curtain of rain four boats standing straight up in a calm spot surrounded by a wicked looking sea. Before we realized what was happening, we found ourselves becalmed in the same spot, but were able to carry way back into the edge of the squall. In a matter of fifty yards we were in the howling wind again continuing to sail a course almost to the east. We came to what looked like a narrow spot in the calm area. Through this we went and were met almost instantly by a wind blowing equally hard from the southwest. The long close reach through the dark rainy night for the Kitchen Shoal-lighted buoy was nervous work. Everyone was aware of the fate of the *Elda* which, in the race two years before, had been wrecked on the coral reefs north of Bermuda. The radio direction-finder helped with bearings on the two stations of the island, but the rough sea made these unreliable. In a clear moment between rain squalls we saw the loom of the lighthouse on Gibbs Hill as its occulting light shone on the clouds overhead. A little later the light itself appeared over the horizon bearing about southwest where we had hoped it would be. Half an hour later the outer breakers lighted buoy on the edge of the shoals was sighted. From then on it was a beat up to Saint David's Head at the eastern end of the island. It was very dark and the number of lights on other boats which appeared out of the night was, to say the least, surprising. One had to keep a sharp lookout as we stood in on the port tack for other yachts converging with us on the starboard tack. One half hour after midnight on Wednesday morning we crossed the line be-

Crew Photo by Rosenfeld, N. Y. G. Clowes, Jim Wickersham, Charles Coles, Ben Williams, Dick Copplestone, Bob Loomis, James Jackson, Worth Loomis.

tween an anchored British destroyer and the lighthouse on St. David's Head. This we did in company with several other boats all burning flares and flashing our code numbers to the Committee near the lighthouse. Imagine the confusion of having more than fifty boats finish within an hour. Hove to near the line, we watched a procession of them sail up out of the night to finish.

When the anchor was at last down in St. George's Harbor and the sails furled, *Aquila* seemed unreasonably quiet. Someone remarked that it was unthinkable to finish a Bermuda Race without a drink to celebrate the matter. Despite the fact that it was 3 o'clock, a bottle was opened, and we solemnly sat around the cabin table to drink a toast to the ship and ourselves. First one and then another fell into a bunk and was asleep. Never did so many drinks go unfinished.

As we peacefully sailed up the long channel to Hamilton the next morning, various of our rivals went by under power passing remarks as to how we must have used up all our fuel on the way down in the race. To our delight upon entering the harbor at Hamilton, we were shown by the customs launch to a mooring off the Royal Bermuda Yacht Club. There alongside of us were George Nichols' *Magic* and Rich Warren's *Narwhal.* Then came the happy moment when the wives came over the side from a launch. Amid laughter and picture-taking they told us we had done well. How well no one really knew until the Committee had sorted out the mess and figured the handicap time allowances. When the shouting was over, we found two days later that we were sixth in our class and thirty-second in the fleet. We were proud of *Aquila.* She had proven herself on the high seas where there are no harbors or refuge.

DIAGNOSIS DEFERRED

The Female of the Species

"A gallant Irish practitioner," according to the *Boston Medical and Surgical Journal* of July 26, 1883, "taking up the cudgels for the ladies, says he can see no earthly reason why women should not be allowed to become medical men." This courtly Hibernianism came late in the battle for the introduction of women to medicine, nor was the entering wedge the graduation of Elizabeth Blackwell from Geneva Medical College in 1849, despite the announcement last fall from Geneva (New York) that Elizabeth was the first woman doctor in the world. She was indeed the first known graduate of a chartered medical school in modern times.

The success of women in medicine or in any career they really set their hearts on has for some time been conceded, as witness the Amazons, Tugboat Annie and Catherine of Russia. So far as the healing mission is concerned they have always smoothed the troubled seas on which men seem destined to embark — more often in nursing than in medicine, although in ancient times these distinctions were not finely drawn. Thus, when " 'omer smote 'is bloomin' lyre," as Kipling coyly phrased it, the blind poet found that Helen, Zeus's daughter, on acquaintance with Odysseus and his shipmates, "presently cast a drug into the wine whereof they drank, a drug to lull all pain and anger, and bring forgetfulness of every sorrow."

But this early use of a meprobamatic prototype is merely background music; by the same token certain of the Borgias and Medicis, female, might be classed as physicians, or at least toxicologists. More substantial is the claim for the "ladies of Salerno," Trotula, Rebecca and Constanza, said to have practiced medicine at least as ably as the male physicians of the period.

Elizabeth Blackwell, this country's authentic first female recipient of a medical degree, was a native of Bristol, England. Having achieved her academic objective and pursued a medical career with industry and distinction, she lived thereafter to the not inconsiderable age, for a physician, of eighty-nine, dying in 1910. She presumably slipped into and through Geneva Medical College when the authorities were looking the other way. Her sister Emily was less fortunate; having matriculated at Rush Medical College and having finished a term she was denied a second one.

Things, however, like Noah's Ark, which also had its female complement, were movering. The Boston Female Medical College, later transmuted into the Boston University School of Medicine, received its first class in November, 1848, and the Women's Medical College of Pennsylvania was incorporated in 1850. Soon thereafter the Blackwell sisters and Dr. Marie Zabrzewska founded the New York Infirmary for Women and Children and the Women's Medical College, and the deed was accomplished.

Harvard University viewed these ventures with a collectively fishy eye, but was not interested in the coeducational market. One learns from various sources that in 1878 Marian Hovey of Boston offered the Medical School $10,000 if women could be admitted, but Harvard still could not be bought — not for $10,000.

A few years later Edith Varney sought admission to the School and obtained the willing aid of Dr. Henry I. Bowditch in trying to get her foot in the door. The following brief correspondence was published in the *New England Journal of Medicine* on November 17, 1949, under the somewhat misleading title "Never Underestimate the Power of A Woman."

Harvard University
Cambridge, September 22, 1890

My dear Dr. Bowditch,

I regret to say that there is as yet no provision for the medical education of women either in Harvard University or by the Society for Promoting the Collegiate Education of Women. Please excuse the delay in replying to your note of September 13th. It was first forwarded to Mount Desert and then returned to Cambridge.

Very truly yours,
CHARLES W. ELIOT

Peterborough
September 24, 1890

Miss Varney
Dear Madam:

I am not surprised at the tenor of President Eliot's reply, which I enclose. I deem the position of Harvard in regard (to) the education of women, one of which *eventually* the University will be *thoroughly ashamed.*

Even the word "Annex," which is connected with the Academic Department shows its low estimate of women. I never can think of it save with a certain contempt for the proud self-sufficiency evinced by the term. The Corporation virtually says "You women shall not join in the Academic Rule because you are inferior to us; but as you want to learn something, we will have a small center connected with our University; an "Annex" and the professors, who choose to do so, are allowed to teach you in certain departments. But in this Department of Medicine in certain courses of which woman is fitter than man to practise the art — we will never teach you.

Thank Heaven! other universities in this country and in Europe have higher ideals in regard to women.

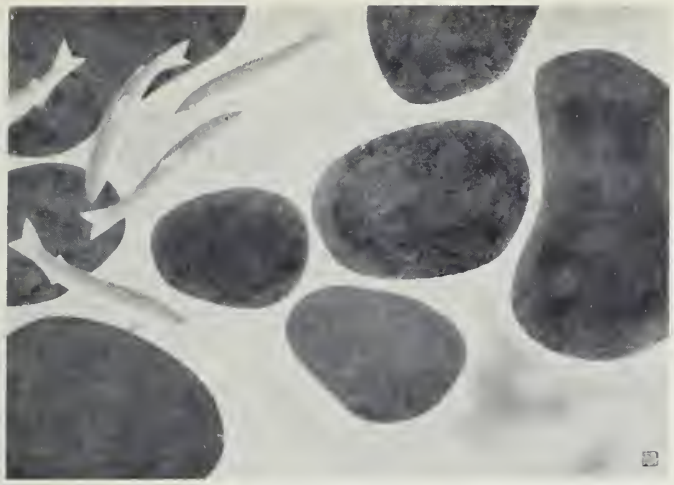
I regret that I cannot help you, but if you think (of) any further counsel I can give you I hope you will write again.

Respectfully yours,
HENRY I. BOWDITCH

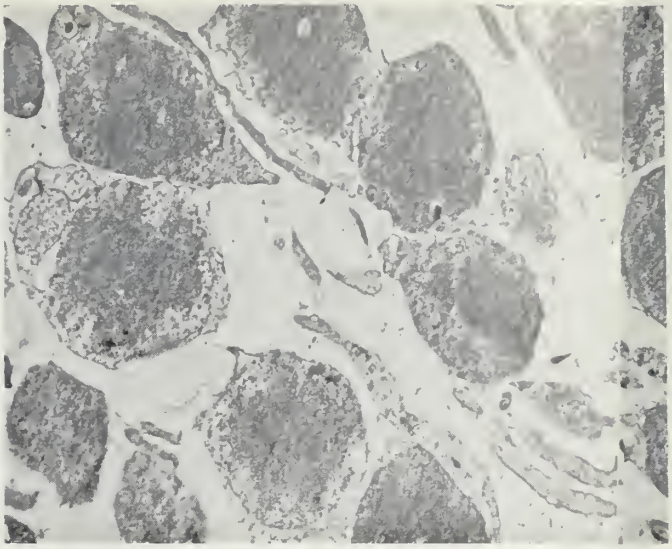
History records that Miss Varney graduated from Boston University School of Medicine in 1893 and practiced in Lynn for fifty years.

This particular campaign in the war between men and women came to its close in 1945 with the fall of the last outdated fortress (fem. ending). In that year Harvard admitted a group of 12 women, chosen from 88 applicants, and 12 were graduated in 1949. Only one change is recorded in the dozen, of a student who quit to be married and was replaced by a transfer from Columbia, already spliced.

Now entrenched in the former deanery of Vanderbilt Hall the female of the species, according to all the overwhelming evidence, has come to stay.



'Ayu' Fish, by Heihachiro Fukuda. Silvery river trout flicker among the stones.

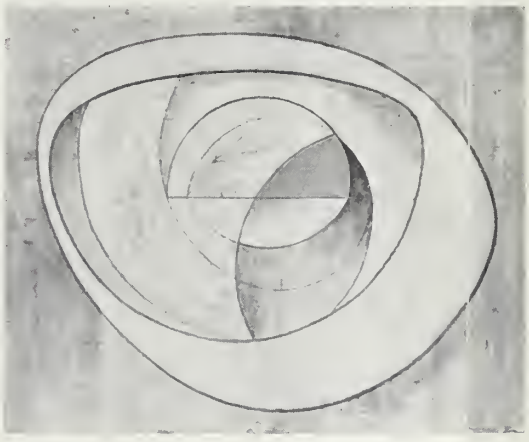


Nuclei of rod cells of the retina. The fish-like objects are protoplasmic extensions of rod cells. Electronmicrograph is by Dr. Aaron J. Ladman, Associate in Anatomy at H.M.S.

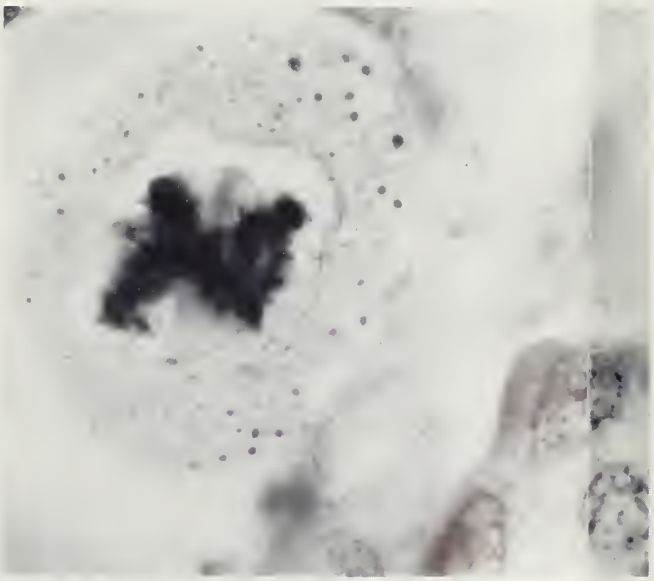
THE ART OF MEDICINE

On the following four pages, technical photographs are compared with examples from the fine arts. We do not intend to show any relationship in meaning between the two; but we hope that their similarity will suggest a richness and beauty in technical photography to supplement the beauty every doctor sees in his own slides.

The Green Caves, 1946, by Barbara Hepworth. Gouache and pencil. The Lefevre Gallery, London.



Night Mirror, 1947, by William Baziotes. Oil on canvas. Collection of Mrs. John D. Rockefeller III.



Malignant cell in mitosis. Photomicrograph for research by Dr. Olive Gates, Clinical Associate in Pathology at H.M.S.

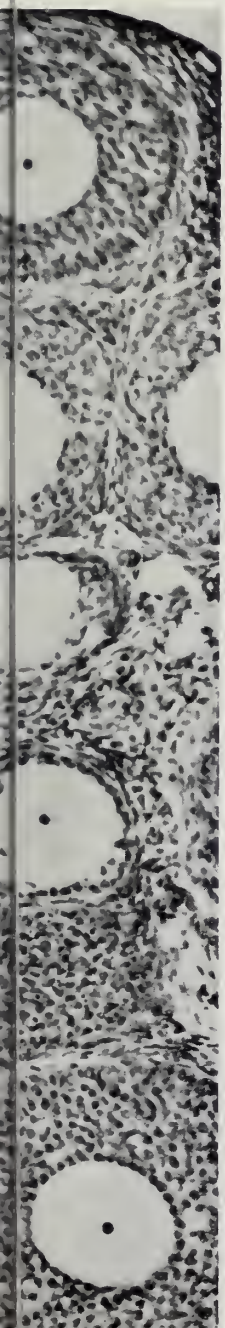
Imported fire ant pupae: two worker pupae and pupa of a winged female
Edward O. Wilson, Associate Professor of Zoology, Harvard

Ovarian tissue from hypophysectomized immature rats; for research on pituitary hormones. Electronmicrograph by Russell Barrnett, M.D., Assistant Professor of Anatomy, and Aaron J. Ladman, Ph.D., Associate in Anatomy at Harvard Medical School.

The Starry Night, by Vincent Van Gogh
Van Gogh had once wanted to be a preacher. Later, he connected religious feelings with his nocturnal painting. An almost humorous note is added to the comparison by quoting Professor Meyer Shapiro: He suggested that "There is, in the gigantic coiling cloud and in the strangely luminous crescent . . . a possible unconscious reminiscence of the apocalyptic theme of the woman in pain of birth, girded with the sun and moon and crowned by the stars, whose newborn child is threatened by the dragon (Revelations 12, 1 ff)."

From *Vincent Van Gogh*, Meyer Shapiro, Henry N. Abrams, Inc.

ger). Courtesy of Dr.
versity.



Translucent Jade Monkey and Young, holding symbolical peach branch. Early K'ang Hsi Period (1675 A.D.) Collection of Mrs. Emma Joseph.

Pupa of a large ground beetle. Photographed by Muriel V. Williams, former Research Technician, Massachusetts General Hospital.

Influenza virus. Photomicrograph by Dr. Barbara K. Watson, Research Associate in Bacteriology and Immunology at H.M.S. The quality of this photograph, resembling glowing coals, is similar to many of the works of the American painter, Albert P. Ryder. Ryder, however, worked for years to achieve this effect. It has been written that "There is tragicomedy in Ryder's drive for perfection, forever reworking his canvases, polishing and changing, scrubbing, rubbing, scraping loading, and coaxing them to a perfect pitch of surface until the colors glowed like banked fires."

Three Hundred Years of American Painting, Ed., Alexander Eliot, Time, Inc.

Toilers of the Sea by Ryder (below) hangs in the Metropolitan Museum of Art.

MEDICAL EXAMINATIONS AROUND THE WORLD

John P. Hubbard, '31

Professor of Public Health and Preventive Medicine
University of Pennsylvania School of Medicine

PERHAPS Phineas Fogg would have found a certain sameness in his trip if it had been limited to modern air travel. But my wife and I found nothing monotonous in 60 days around the world, even though this trip did not include travel by elephant, wind-blown rail-scooter and self-consuming packet. Stops in 36 countries from Los Angeles westward to Philadelphia and south to Mexico and South America, and a bird's-eye view of medical education around the world offered diversity and interest aplenty.

The reason for all this was the Educational Council for Foreign Medical Graduates. This recently organized Council, now becoming known as the ECFMG, was born of the need to establish standards for the qualification of graduates of foreign medical schools who wish to come to the United States for appointments as interns or residents or for licenses to practice medicine. Physicians around the world are aware of the advantages to be gained from clinical experience in American hospitals and have been coming to these hospitals in ever increasing numbers. Nearly 8000 graduates of foreign medical schools now hold internships or residency appointments in hospitals throughout the United States. At the same time American hospitals are anxious to obtain the services of foreign medical graduates to augment the supply of interns and residents. Hospitals list over 12,000 internships and our medical schools are currently turning out somewhat less than 7000 graduates to fill these positions. Some way to control this twofold situation has been a pressing problem.

Heretofore, reliance has been placed upon a list of foreign medical schools published annually by the American Medical Association. The graduates of these listed schools have been recommended for consideration on the same basis as graduates of approved medical schools in the U. S. and Canada. In recent years, it has become increasingly apparent that the AMA cannot obtain and maintain adequate and current information concerning the educational programs of medical schools all over the world. Furthermore, is it really the business of the AMA to sit in judgment on the quality of medical education in a medical school which exists in a very different social structure and which must necessarily prepare its graduates to meet different demands on their medical skill? We are, however, rightly concerned with the qualification of those individuals who hold — or seek to hold — appointments in American hospitals and practice on American people. Accordingly, the objective has shifted from evaluation of the foreign medical school to an evaluation of the individual graduate.

After nearly three years of planning, the ECFMG requested the National Board of Medical Examiners to cooperate in the preparation and administration of an examination, specially designed for foreign medical graduates, to be given throughout the world wherever there are foreign graduates applying for appointments in American hospitals. To establish examining centers on a world-wide basis was indeed a formidable assignment, especially since it became very clear that this could not be accomplished satisfactorily by remote control but only by personal visits to the proposed centers. Hence, all the traveling which fell to my lot as Secretary of the National Board.

In one sense, the mission appeared simple enough: to find just one person in each proposed center who could be relied upon to administer examinations under conditions of security control. But, allowing about two days for each visit, how was this person to be found? The closer we came to the day of departure, the more baffling the answer to this question appeared. International organizations such as the I.C.A. and the International Division of the Public Health Service were not enthusiastic about assuming responsibility. Members of American medical faculties are to be found visiting many foreign universities, but can they be counted upon for a continuing program? Should the supervision of the examinations be handled by U. S. Embassies or by foreign offices of U. S. Information Service? The State Department (I.E.S. Division) agreed to send a memorandum to all stops on the itinerary, informing the CAO's (Cultural Affairs Officers) about the program and the date of my visit. But this memorandum gave no assurance that Embassies or U.S.I.S. offices would accept responsibility for the supervision or administration of the examinations. The Department of Defense offered more substantial help. The Surgeons General of the Army, Navy, and Air Force, with effective interservice coordination, designated the military establishment available in each area which was then authorized to conduct the examinations if requested to do so. The State Department, however, was not very happy about the idea of a military-looking doorway through which a foreign physician would have to pass in order to gain access to an American hospital. With such uncertainty in the preplanning, it was tempting to look for Harvard medical alumni around the world — and the chances seemed good that at least one might be found in or near any important city.

In most centers, however, CAO's and Consuls were most cooperative, being already deeply involved in the problems of foreign physicians applying for positions in American hospitals and seeking U. S. visas. In fact they (a generalized rather than a unanimous "they") welcomed the introduction of a procedure which would provide a valid reason for refusing an exchange visitor's visa for a physician with little or no knowledge of the English language and with dubious medical background.

Also, in most of the countries visited, there was a favorable reaction on the part of medical school deans, ministries of health, and other medical authorities. They, too, in many instances had been dismayed at the ready acceptance of inadequately prepared physicians for appointments in American hospitals. Such individuals not only give a poor impression of medical education in the area from which they come, but also are unprepared to profit from the experience. One hears plenty in foreign lands about the "exploitation" of foreign physicians by hospitals that seem to be more interested in acquiring an additional pair of hands than in their responsibilities for graduate education. More attention to the preparation of the incoming physicians engendered the hope of more attention to the medical supervision and training of these physicians.

Those countries now having medical schools on the AMA list had, rather understandably, limited enthusiasm for the program. Their graduates can now come to the United States on a no-questions-asked basis. But these countries generally accepted the change with an air of confidence that their graduates should have no undue difficulty in passing an examination in competition with the graduates of "unlisted" schools.

In those areas not having medical schools on the AMA list, especially in Latin America and Asia, the new plan, when fully explained and understood, was welcomed as a means by which any graduate of any medical school anywhere, irrespective of an AMA appraisal, might have equal opportunity with all others to demonstrate his own individual competence. Since some measure of qualification is deemed imperative, an evaluation of the individual is preferred to an evaluation of his educational institution.

It now remains to be seen how well the system will work. The initial mission was successful in that reliable and secure examination procedures were set up in every center visited. And just in time too, for the journey ended on August 30th and the first world-wide examination was scheduled for September 23rd. On this day, 844 graduates of foreign medical schools reported for the examination not only in previously established centers in the United States but also in 30 centers from Tokyo to London and from Mexico to Buenos Aires.

Back in the home office we waited with considerable anxiety to see if our hard-won arrangements would proceed as planned. Would all examinees arrive on time at the assigned locations? Would all examination papers be shipped back through prescribed channels without loss? Most important of all, would foreign physicians be able to handle the objective, multiple-choice type of examination which is familiar to our own students but not so familiar to students and physicians abroad?

It may now be said that all went well in this first administration of a world-wide medical examination. The results were scored, tabulated and submitted to the ECFMG, which holds the responsibility of interpreting the results and reporting them to the persons concerned. Furthermore, the program is rapidly gaining recognition and understanding: all indications now point to a registration of two to three thousand foreign physicians for the next examination in February and a similar number for another examination later in September, 1959.

ALPHABET SOUP

James Cox, '60

If you had had occasion to stroll through the Peter Bent Brigham OPD one dreary morning last October, you might have been attracted to the Orthopedic Conference Room by a rumble of angry, incoherent mutterings, occasionally broken by shouts of more conventional profanity. Had you peeked in, you would have seen our third-year surgical group hunched over the table, and you might have marveled at the wisps of steam that intermittently popped from beneath our hot and sweaty collars. An astute listener would soon have realized that the topic of conversation, in phrases more suitable for publication, was in essence: "How in hell can anybody make any sense out of the goddam abbreviations in these goddam records?"

After several minutes of elaborating on this theme, one of the more mercenary minds in the group had blown off sufficient hostility to leave room for a magnificent insight: why not collect and codify all the abbreviations used in the

Brigham records and sell them to future incoming surgery groups? In the next eleven minutes, four frustrated intellects free-associated to exactly one hundred and forty such abbreviations that had at one time or another been barnacles on their respective educational bottoms. The list has since exceeded one hundred and fifty and shows much promise of continued growth and differentiation. And since the list has been alphabetized, it exceeds in value even that "4 years of medical school in one volume," the Merck Manual. No little black bag at the Brigham should be without one.

Dear reader, if we exclude the more florid psychiatric cases, I challenge you to show me anyone who outdoes the medical man in the gross distortion and confounding of the English language. It does seem that a physician will lose status among his peers if he employs one word of two syllables where three of five could be invoked. He has a dozen ramparts, such as "idiopathic," "anomalous," and "of uncertain etiology" behind which he can retreat while keeping the lay at bay with a polysyllabic barrage. To the experienced clinician a legible entry in a record can mean only one of two things: either a stranger in the house is juggling things for a compensation case, or some bright-eyed, bushy-tailed, third-year student is too naive to have acquired all the stigmata of medical sophistication.

You have all known the stark terror of being told that in thirty minutes YOU will present a complicated case before one of those Olympian gatherings of medical talent to which the profession in Boston is inclined: The rush for the record! A place to work! "Oops! Conference! Sorry! . . . Nurse, may I work over there at that . . . oh, sorry." Finally in a dark corner of the dog lab you finger frantically through the record. You turn to Present Illness only to read the Pathology Report. Skillfully you flip to where the Pathology Report ought to be and abstract the System Review. Your fingers grow numb as you pencil the little notes on the little cards which will lie as an inconspicuous teleprompter on the patient's bed.

Pearls that an intern once cast before you race through your mind: "chronology is important" . . . "don't mention murmurs in a surgical conference; it only confuses them" . . . "be brief; be brave," . . . "chronology." A final scribbled note, then the rush to the amphitheater!

So where's the problem? Even though you didn't know what they meant, you copied all the abbreviations. But how were you, with your previous experience limited to the logical, orderly records of the Mass. General,* how were you, in your haste, to realize that Peter Bent Brigham records read from back to front? We envisage the following history-making presentation which gets only this far before medical aid must be summoned for the house:

"Eh, this is the first Peter Bent Brigham discharge of Mrs. Zelda Smurdley, a fifty-five-year-old, white, gravida-2, para-2, female who left this hospital with the chief complaint of anterior upper-right thoracic pain and coughing up of blood which began 10 days ago. Mrs. Smurdley's past history is unremarkable except for a combined abdominal-perineal resection for a mitotic large bowel lesion which was performed at this hospital 18 days prior to discharge. The physical findings included an extremely spastic sphincter on rectal exam. . . ."

Or take the case of Edgar Freen, boy medical student, whose altruistic soul and adventurous spirit led him to do volunteer duty in the Emergency Ward one Halloween night. His first assigned task was to attempt to elicit a history from a wheezing and cantankerous Irishman who was on the verge of *status asthmaticus.* (The neighborhood children had playfully propped a full vacuum cleaner bag over his door and rung the bell.) Freen inadvertently let his patient see the record as he entered the chief complaint in approved medical style: "S O B." One second later he was picking himself up from the EW floor, removing the record from his mouth, and watching his patient lurch toward the exit and a new position in life as a medical examiner's case. Feeling that the least he could do for the deceased would be to have him go out with a complete record, Freen returned to his desk and made the following eloquent improvisation upon his original entry:

> "This 62YO W/D W/N W/M
>
> arrived DOA at EW c CC SOB.
> SR, PH, FH, or SH not elicited because of SOB.
> Pertinent PE: NSR.
> Imp: ? CVA
> ? MI
> Disp: Path (hold for ME)
> Freen, HMS III

If it is true that the patient's record is a legal document, admissible as evidence, my heart goes out to the defense attorney.

Here are a few examples which illustrate the inadequate basis for earth-shaking decisions which the medical student must make:

1. If the record shows an "AP", would you recommend a serum

*Editorial hearts, which bleed for the Brigham, hasten to quote that instrument of precision, our esteemed contemporary, the *New England Journal of Medicine.* A distinguished English exchange Professor, pro tem, at *Massachusetts General Hospital* wrote recently:

"I expected to run into trouble with abbreviations, though, of course, these are used in England, and it is some while since PBI stood for poor bloody infantry, at least in endocrinologic circles. In fact I only tripped up once in a case of backache that I attributed to PID, for there was no time to write out prolapsed intervertebral disk, only to learn that these initials connote pelvic inflammatory disease in Boston."

From "A British View of an American Hospital," J. F. Stokes, M.D., V. 260, No. 2.

amylase or brush it off as senile emphysema?

2. The record states this patient has a "+CVA." Would you expect to see a hemiplegic or a person with kidney disease?
3. As a student, how would you differentiate between Congestive Heart Failure and a Coccyx that was Hard to the Finger?
4. How can we make the X-ray people differentiate between a Fecal Bolus and a Foreign Body?

Would it be fair to say, then, that we are faced with a self-perpetuating system of hieroglyphics, indigenous to a profession whose penmanship is notoriously illegible, and where each specialty and even each hospital has a well-entrenched variety that is peculiarly its own? It would seem so. But corrective measures are afoot: To any student making an illegible entry in his department, an orthopedic surgeon of our acquaintance assigns a thorough reading and understanding of the thickest record he can lay his hands on; this makes the point quite adequately. But how long might it take one to decipher an entry by this same surgeon, "P/3 D/P Fx c.c.," as a compound comminuted fracture of the proximal third of the distal phalanx?

Maybe the whole mess will eventually reach a point where the medical student's conversations begin to sound more and more like Victor Borge's "phonetic punctuation" routine, and a student might report his day's activities to a roommate something like this:

"Had a great pt. today."

"Oh? M or F?"

"F, you idiot. You don't get many M's in an OB-GYN OPD. Though it did turn out she was in the wrong dept."

"W/D?"

"Ummmhummm. W/N, too. I've always been a great admirer of Reubens, you know."

"What was the Dx?"

"Don't think they have one yet. Started out as pseudo-pregnancy till they found out she'd had a p.p.s. Funny thing. That was a waste of money. She claims they got the tubes mixed in an A.I.D. procedure and she came down with a roaring GCPID. Cheap surgery, huh?"

"Yeah. But what'd she have an A.I.D. for?"

"Seems hubby is an 'older' man. He was in here for BPH last year, had a TUR, and something slipped. Ergo, an A.I.D."

"What CC?"

"Tummy-ache. Real crocky. Hx and Sx for any Dx. Anything from SBO to PUD c a few C-R Sx thrown in. Chart reads like a Dorland."

"Any o.c.c.? Sure sign of a hysteric, o.c.c."

"Sure, but she didn't mind a good thonk on top of the head, so I figure she's crocky."

"Where's she hurt?"

"URQ, LRQ, ULQ, LLQ . . . you point to it. She hurts."

"Unhappy childhood?"

"Understatement of the year. Took a PH. Could hardly stop her. Oh yes, UCHD. And a touch of ARF. Her LMD told her she had residual RHDcMS. Wants to see Harken when we're through with her. I played along. But her LBCD is right on the MCL, and the racket in the place is such that even a Gr IV M would get by you. But no other suggestive C-R Sx . . . PND, SOB, DOE, ETC."

"What's 'ETC?' "

"et cetera."

"Oh."

"Almost as bad as her FH. Poppa has ASHD, an old MI, and a TT STG for a DUD or ? CA, and just loves that EtOH. Mama had AFB problems, spent a couple of years at Mattapan. And a Cx CA 2y PTA. Snip. 2 sibs, L&W, and one d: bilat. BK courtesy of a freight car he was sneaking a ride on."

"Pertinent SH?"

"Like a fish. I'll bet the AM ASA intake alone could account for her Sx."

"And after all this, what on PE?"

"PE? I told you. You point to it, it hurts. HEENT nl, PERLA et al."

"What's 'et al.'?"

"et alibi, but don't let it worry you. Cf supra."

"OK."

"C-R OK to P&A, NBS, but I told you it's noisy there. Abdomen nl, no LSKM, but NBS: real quiet. The Hx on PI had NVD 2D PTA. P&R nl, except I sent for a TPI to be sure. Got back a QSH."

"Any lab findings?"

4+ benz. Asked for a CBC and got back a Hct 23 just before I left. SAR wanted a Tx, so the JAR was phoning for a unit of FTSCM-CWB to be sent up. Had a JAR start here on IV 5 D/NS. I don't know; you go ahead on that with just one LVH?"

"Nope. She wasn't shocky, was she?"

"No. Oh well, they'll get a KUB on her tonight and tomorrow we'll have at her again."

"Well, YMD, what's her Px?"

"What d'ya mean, YMD. You know an HMSIV when you see one?"

"Sorry."

"OK. Px? 2 possib. VNA or CPC."

"Well, goodnight."

"g-n."

SAFE DELIVERANCE: A POSTSCRIPT

Joseph Garland, '19

THIS particular occasion, I realize, is by way of paying homage to that line of distinguished Harvard professors whose labors have resulted in the establishment and continuing services of the two hospitals whose alumni you are. It is, however, more especially a *Sicherrettungsfest* in honor of our late colorful and robustly intellectual colleague, my friend and one-time neighbor, Dr. Frederick C. Irving. With such an objective for the evening, it appears to be my assignment to present a fantastically brief postscript to Dr. Irving's masterpiece, *Safe Deliverance.*

Fritz Irving had the distinction of being three inseparable individuals in the large community of appreciative persons that he enriched so picturesquely. He was first and foremost a skilled and spirited obstetrician. He was a master of verbalization, both oral and written, both professionally and in the quieter interludes of his life, and he was, purely by avocation, a painter, even as others who have conquered Olympus in the service of mankind have employed brush and canvas as a release for the gentler aspects of their natures.

I remember how, after the safe deliverance of my first-born child — it was before Blue Shield had made it possible to anticipate such obligations and they were usually arranged on a C.O.D. if ever basis — in my callow ignorance I presented Dr. Irving with a framed picture, hoping that he would consider it as a suitable quid pro quo. Imagine rewarding Fritz Irving with the gift of a picture! Imagine bestowing a ten-cent tip on the director of the Mint! I think the subject was Hadrian's Tomb. Not until later did I realize that Irving at his worst was a better painter than Hadrian at his best, of any subject.

Few persons even in Dr. Irving's own line of business realize the exhaustive studies in obstetrics to which his consuming interest had led him. They culminated, of course, in the publication of his famous autobiographical and historical textbook, already mentioned. In this work, now a collector's item, its author's interest in semantics and his complete mastery of verbalization have been happily combined to produce a graphic presentation of the obstetric specialty that has no equal. The chapter on the discovery of the cracked-pot phenomenon through the chance encapsulation of a youthful head in a china thunder jug would be worth the price of the book, were it obtainable.

As might be expected of Dr. Irving, his investigations in parturiency went back to the beginnings of that interesting biological experience. Parturiency, according to Mr. Webster, refers to the act of "bringing forth, or about to bring forth, young," — but figuratively, and this is where Irving enters the picture — it may also mean "about to produce an idea, discovery or the like."

Dr. Irving, in fact, carried his researches back to the primordial protoplasmic ameba (Latin, *amoeba*), the first zoological entity to undergo parturition or even partition; the first example of the primitive obstetric phenomenon; the first instance, undoubtedly, of the split personality. By this relatively simple divisive act the first ameba was probably also the first living creature to sacrifice the simple joys and homely virtues of virginity for the harrowing problems of parenthood.

There are those who may consider Adam as the first ameba in a symbolic sense, or vice versa, and this point of view is to be respected. In either case the first woman becomes almost a product of parthenogenesis although, since Webster defines parthenogenesis as the development of eggs from virgin females, this gives a curious twist to the whole situation. It also appears to let Adam out of any involvement in the parthenogenetic process, although there are still various biological elements in his side-splitting experience that require explanation, such as its analogy to the role of the virgin sturgeon in producing caviar.

Safe Deliverance is an invigorating book written by Dr. Frederick C. Irving, '10, late Professor of Obstetrics at the Lying-In Hospital in Boston. The book is essentially a free wheeling history of the Lying-In Hospital; and a commentary on the development of obstetrics in Boston, well documented with anecdotes. By way of a postscript, Dr. Garland presented this address at a combined meeting of the alumni of the Boston Lying-In Hospital and the Free Hospital for Women on October 24, 1958.

As a matter of fact, after Adam's delivery of Eve and before his deliverance from her, might not their unabashed intimacy be considered as in a way at least unorthodox? For was she not flesh of his flesh and blood of his blood? I have never heard that Dr. Irving delivered an opinion on this relationship or in fact concerned himself with it.

It is possible, I suppose, that Adam's genetic thoracotomy might be likened to an amebiatic response if it was not, indeed, the world's first experience with human amebiasis. If Dr. Irving had considered it at all he would have found it within his semantic purview, although, with his peculiar etymological gift, he always insisted that words must have meaning. He was thus a life-long disciple of what may be simply termed antiartificial semanticisticism — the doctrine that if you must use big words, don't invent them.

Not long ago that instrument of precision, the *New England Journal of Medicine,* adverted on a contribution to the *British Medical Journal* by Richard Asher, M.D., F.R.C.P., of the Central Middlesex Hospital of London, on "Why Are Medical Journals So Dull?" Among various sound reasons Dr. Asher mentioned the dullness and prolixity of the titles of articles. If the usual custom were followed, his own, or so he fancied, might have been: "A Study of the Negativistic Psychomotor Reactions Induced by Perusal of Verbalized Clinical Material." But you see what I mean — in which case you perhaps have the advantage of me.

One is reminded of the claudicatory controversy, sometimes participated in by various of our colleagues, including the late Dr. John Homans, who always objected to the apostrophe that sundry writers, when referring to the sign that he had discovered, introduced before the "s" with which his name terminated. "Who is this dashed 'Homan'," he would say, "and what is his blankety-blank sign?"

Claudicate, although of what it has to do with obstetrics I have no notion, has come to be used colloquially to indicate intermittent pain or spasm, not as in labor, but as in walking, despite its derivation from the Latin *claudicare,* to halt or limp. We must also consider, however, claudent, shutting or closing, from claudere, to shut; claudetite, or native arsenic trioxide crystallizing in the monoclinic system, and Claudian, "of or pertaining to any of several celebrated Romans of the name of Claudius." "And if this be treason," as Patrick Henry once said, "make the most of it!"

But to return to Dr. Irving's studies on the long history of parturition.

The quiet propagative genius of the ameba, exquisite in its simplicity, became more complicated in the slightly higher animals as life itself became more complex. Those early colonizers, the sponges, made a sport, a Mendelian one, it is true, of the process of reproduction by sending off buds to form little sponges; jelly-fishes introduced the custom of producing eggs and then fertilizing them in a single lonely act. The worm that turns, turns on itself and produces more worms to carry on the mysterious function of turning.

And so life grew and multiplied and ramified until finally it unfolded into the heterosexual concept with which all obstetricians and many others are familiar. First the extroverted passion of such humble and industrious creatures as the bees and their fellow arthropods developed, and then the fishes of the sea, both oviparous and viviparous, came into being, and the birds of the air, with their massive, multifunctioning cloacae, like one-pipe furnaces, rendered particularly significant for you by the bird of your calling, the stork (Ciconia Ciconia, family Ciconiidae), with its tender burden so familiar to all practitioners of midwifery.

Those of us who remember the building of the present Boston Lying-In Hospital will remember also its original weathervane of an unbalanced gravid stork, perpetually backing into the wind.

From these warm-blooded creatures it was but a short step, in such a comprehensive investigation, to the mammals that not only bear their young alive but suckle them as well — or such was nature's original intention before the purely decorative human female silhouette came into vogue.

The orderly progression of evolution onward and upward was thrown off a little by the non-placental marsupials, but this attempt of nature to put the system out of balance was readily rationalized by Dr. Irving, who also first directed the attention of the scientific world to the fur-bearing duck-bill platypus that lays its eggs and broods over them and nurses them when hatched.

From various sources knowledge has been garnered regarding the more and more refined conduct of safe deliverance among less and less primitive peoples, even to the not illogical custom of having the husband travail on his own account — letting the punishment fit the crime, so to speak.

But there is no need of my belaboring such an audience with any secondhand account of obstetric stools shaped like a bootjack or a V for victory, inverted, or of obstetric chairs designed as if by Mr. Perkins for another purpose. With the primitive postures assumed in labor and the part that the husband may play in it aside from that of simulating the function, you are more familiar than am I. You, too, are no doubt painfully aware that among the Apaches the parturient squaw was strung up to a convenient limb by a noose — fortunately placed under the arms — putting her literally as well as figuratively up a tree, and that in Indo China it was once the accepted cus-

tom to expel the fetus by trampling on the abdomen, even as the vintage where the grapes of wrath are stored was trampled out in Julia Ward Howe's *Battle Hymn of the Republic.*

And finally may I cite the practically modern method of substituting a rocking chair for the child bed — well known among the sophisticates of your art, I presume, as accouchement rococco.

Even as you no doubt have in mind the familiar proverb of the mountain that labored and brought forth a mouse, it is probably also obvious to you that my remarks so far have been merely introductory to the main thesis of my discourse, like the massed bisons in the frontiersman's story, that thundered over the plain for three days before the main body of the herd came into sight. It is also the culmination of Dr. Irving's great labor, the story of which I have told with such claudication, and which has to do finally with the safe deliverance of the conceptus, as well as with his telling of it.

His view was aptly expressed in the *Harvard Alumni Bulletin* only a few days ago, among other pointed sayings, under the fitting title "Harvard in Epigram." "A woman doesn't come to this Hospital to get over a case of pregnancy," said Dr. Irving, "she comes to take home a baby."

This seems to express the obstetrical function, with all the aid that can be given it by the pediatricians and the subsequent tidying up by those who practise the plastic art of gynecology whether or not they were also involved in the delivery. And the art, or the science, has made general progress toward Fritz Irving's goal of safe deliverance. In some places it has even gone full circle, abandoning "hooks and bands and tongs and hands," back to natural childbirth, the most primitive method of all, as practised on the district by the student externes of the old buzzy-bell era. Whether an art or a science or both, its roots, I understand, are sunk deeply into the soil of New Haven, Connecticut.

In this relation we are told that the mammillary function itself is coming back to a degree of popularity despite all efforts to the contrary.

In respect to that traditionally contented if somewhat bovine maternal operation that casts its spell over even the oviparous platypus, Salber and her colleagues — "et al." as they used to say in ancient Rome — have investigated the factors affecting the frequency of breast feeding in the new-born period and have published their results in that *vade mecum* of the medical profession, the aforesaid *New England Journal of Medicine.*[1]

According to these indefatigable workers, breast feeding is coming back, if only among those of the species who might be designated as *femina sap.* The so-called working classes are unshakeable in their devotion to the bottle. It is the sapient college women and the wives of college men who have reverted to the teachings of Oliver Wendell Holmes when he wrote: ". . . we watch the child anxiously whose wet nurse is a chemist's pipkin. A pair of substantial mammary glands has the advantage over the two hemispheres of the most learned Professor's brain, in the art of compounding a nutritious fluid for infants."[2] And the encouragement of his patients to nurse their infants was the final obligation that Dr. Irving assumed to be part of the complex of safe deliverance.

In case you need a reminder that Holmes as well as Irving was a poet in addition to being a champion of the breast over the bottle, let me read a short verse recently submitted to the *Journal* by a medical student at Yale, of all places:

> The modern M.D. and his anomalous yen
> With pen in hand to beat arrythmically
> Some poor failing sequence of prose
> Into a poem (vision of a latter day Shelley)
> Would do better to examine that stool,
> Boil urine . . . . . Sleep!
> For remember —
> O. W. Holmes
> Wrote poems.

REFERENCES

1. Salber, E. J., Stitt, P. G., and Babbott, J. G. Pattern of breast feeding. I. Factors affecting the frequency of breast feeding in the new-born period. *New Eng. J. Med.* 259:707-713, 1958.
2. Medical Essays. Scholastic and Bedside Teaching.

MEDICAL LIBRARY

(Continued from page 15)

solve all of our problems? My answer to this is "no." For one thing, I should regret to see us develop dependency upon Washington; a more constructive principle is to develop the resources of the whole Eastern Seaboard. This suggests the early extension of library cooperation among our sister institutions in New Haven, New York, Philadelphia, Baltimore and Washington. Last Saturday in New York City, about a hundred doctors and librarians gathered at a conference to discuss these very principles; the conference had the theme, "Cooperation or Chaos."

The definition, operating technique and functions of libraries are different today, and our job, as I see it, as responsible residents of the New England community, is to plan for the future. This is a task for all of us. If we pool our wisdom and our energy we can organize for the general welfare library facilities in Boston that measure up to the needs of modern medicine and medical education.

HONORS

Albert H. Coons, '37, Visiting Professor of Bacteriology and Immunology at Harvard Medical School and career investigator of the American Heart Association, has been awarded one of the nation's top honors in the field of public health. He received the 8th annual Kimble Methodology Research Award at the Conference of State and Provincial Public Health Laboratory Directors in St. Louis. The award was presented to Dr. Coons for his discovery of a way to use fluorescent dye and ultraviolet light to diagnose virus diseases.

* * *

Joe Vincent Meigs, '19, Clinical Professor of Gynecology at Harvard Medical School, received the citation for distinguished service from the American Cancer Society. The award recognized Dr. Meigs for "outstanding services to the field of cytology" and was presented to him by Dr. L. T. Coggeshall, President of the Society.

* * *

One presidency and two presidencies-elect of major radiological groups in the United States are held this year by members of the Faculty of Medicine of Harvard University. Dr. Edward B. D. Neuhauser, Associate Clinical Professor of Radiology at Harvard and Radiologist-in-Chief at The Children's Hospital, is president-elect of the American Roentgen Ray Society. Dr. Laurence L. Robbins, Associate Clinical Professor of Radiology at Harvard and Chief of the Department of Radiology, the Massachusetts General Hospital, is president-elect of the Radiological Society of North America. Dr. Milford D. Schulz, Assistant Clinical Professor of Radiology at Harvard and Radiologist at the Massachusetts General Hospital, is president of the American Radium Society.

BOOK REVIEWS

King, Lester S., '32: The Medical World of the Eighteenth Century. The University of Chicago Press, Chicago, 1958. 346 pages.

Dr. King's small volume is warmly recommended to physicians and medical students alike. It is well written, "readable" and there is far more to it than will meet the eye of a drowsy reader.

The Preface gives a subtle warning of what the author is up to by an innocent appearing analogy: without a sound past history of a patient, no physician can intelligently diagnose or treat that patient. The physician's crucial role is to search out the particular details of the past which are significant for the patient's present state. As a medical historian Dr. King selects the eighteenth century as representative of the adolescence of present-day medicine. Then, likening his own effort to that of an expert photographer who is not content blithely to click the shutter at this and that, he consciously selects with an artist's insight, a few studies from the century which to him appear significant in the development of medicine.

For a frontispiece to his album designed to portray the medical world of this adolescent century, Dr. King chooses the conflict between the physicians of the period with their long, costly education, limited numbers and high fees and the apothecaries who were crowding in to fill a medical vacuum in the needs of the people. At the beginning of the century (1703-4) the conflict reached its decisive climax in the trial of apothecary Rose for practicing medicine without a license. The appeal to the House of Lords yielded a decision which recognized that however bad the apothecaries' practice might be on occasion, public policy dictated that it was preferable to the rigid, supercilious monopoly of a few physicians. This decision, called the *Magna Carta* of the general practitioner, allowed the apothecaries to transform themselves into primitive general practitioners.

For the bench mark from which to view changes in the development of medical thought during the century, the reader is presented with a profile of the great Hermann Boerhaave of Leiden. In this, as in the essays which follow, full light is thrown on the intellectual processes of the physician; how he utilized logic and observation and how the scientific processes, particularly those expounded early in the previous century by Bacon, slowly infiltrated medical theory and practice. A chapter is devoted to the dead-end street of homeopathy and its exponent, Samuel Hahnemann. The development of medical ethics is revealed as a measure made necessary by the tense economic and interpersonal rivalry of medical practice. In a modern sense the codes of ethics were traffic regulations.

Dr. King is at his best in his interpretation of the rise of modern pathology, quite naturally because of his personal identification with this field. Pathology, he explains, was originally a *point of view, not a distinctive activity.* It arose in the attempt of the physician to gain new insight and engender new theories of disease. *The pathologist was the man who tried to understand disease* in contrast to *the man who contented himself with empirical correlations, without seeking the how or why.* It was because the data to explain disease in the 18th century came principally from autopsy dissections that the pathologists became linked to the dissecting table and the service function of pathology is the product of specialization.

Starting the century with Boerhaave in whose thinking a residue of medieval scholasticism is highlighted, the century is ended with Bichat and J. Hunter, both claimed as experimental or general pathologists.

The conclusion is that the doctors of two and a half centuries ago were quite as muddleheaded, obtuse, grasping, prejudiced and contentious as they are today and also as perceptive, clear thinking and clever. The profession as a whole carried on its business unaware of the backwardness of its science and its duty to the public, blissfully ignorant of the profound happenings of the two preceding centuries and of the 18th century itself.

Dr. King brings real erudition and philosophic insight to his task. If it is less than wholly satisfactory to the sleepy-eyed reader it is because of the sharp focus on medical affairs and doctors rather than a depth of focus which would have brought out the social landscape in the background with greater clarity. But this the reader can fill in for himself from many available sources. The movement of the profession out of traditional superstition and ineffective practices into the light of science during the "age of enlightenment" is indeed significant. But many aspects were paced by developments in non-medical science as well as the general humanitarian movement of the period connected on the Continent with Voltaire and the "philosophers" and in England with philanthropy and the growing harmony between science and religion. Even in the twentieth century although no longer adolescent, medicine is still immersed in the transition from medical economics to medicosocial economics, and this of course is why Dr. King's book provides pertinent stimulus to thought. After reviewing the past history Dr. King wisely refrains from a diagnosis or prescription for any present illness of medicine; perhaps as a pathologist he is patiently awaiting the autopsy.

Edward D. Churchill, '20

AN OPEN LETTER OF PROTEST TO THE ADMISSIONS COMMITTEE

Dr. Kendall Emerson
Dean of Admissions
25 Shattuck St.
Boston, Mass.

Dear Ken:

I wish to register a protest with the Admissions Committee, and have particular reference to a problem which is best summed up in Kitty Foster. You have no right to let such a creature loose in a medical school where men's minds are supposedly occupied with intellectual matters. Were I less of a pagan I should perhaps describe her in terms of a tempter, apples, Garden of Eden and all that sort of thing.

As you know, she is in my seminar for advanced biochemistry students. At our first session I was thumbing through my notes while waiting for the group to assemble, when I was suddenly aware of a subtle perfume. It did not come like a blast of hot air in a Finnish bath, but rather, as the meteorologists say, "a slow-moving front," or the more religiously inclined "a gradual awareness of a presence." She must have tiptoed in and removed her coat, for she was sitting across the table shining her glasses quite unconcernedly, and when I looked up she smiled and spoke with that honeyed voice, "Nice day, isn't it?" just the way you would say it to a stranger on the ski trails in the mountains.

Most of the female medics look the part, with hairdos that require a minimum of effort and the usual convenient, tweedy outfit that they can slip into or out of quickly and manage to look reasonably neat with a minimum of effort. Kitty wore a black silk blouse with cufflinks the size of half dollars done in matching cameos, and on her left side, about where the areola would be, were discreet yellow letters K.F. I glanced at once at the list of five that your office had sent me, and

there appeared the name of Kitty Foster.

You know well enough about her looks; Good Lord, you must have interviewed her. I'd like to have heard the searching questions you put to that enigma. Auburn hair, a complexion like one just in from a brisk walk in the bracing October air. On that first day I wanted to see her ankles, for I belong to a school that can tell more about a woman from this single feature of anatomy than face, hips, talk or whatnot. This derives from the historical fact that when we were learning about girls, the awful 20's were in full swing. Our co-eds covered their heads with cloche hats and nullified all of the graceful curves with chemises. We were left the lower extremity to cover the entire gamut of sex appeal, and from that period of studious application, I learned to know ankles, and they unfolded to me their code of information. If you want a good, efficient secretary, avoid the heavy calf and fat ankle. They are kind and helpful, will stay after hours until the work is finished; but the girl who can dance is the one with proper secretarial reflexes for my money, and she will have the neat ankle of a gazelle, etc.

Perhaps I shouldn't write this letter, but you, more than any other person, know about my determination to avoid female entanglements for myself. After all, I'm interested only in concentrating on the synthesis of glucosteroids. People sort of laugh when you say that science is your mistress, but that is the way I feel about my research. We are going at a terrific pace (perhaps I should say "were") and already have covered our planned five years' work in three. You may have seen the light in my lab. This does not mean that I am totally immune to the beauties and softness of the opposite sex. If anything, I am like the Frenchman who said, "Every time I see a beautiful woman, I fall in love with her a little bit." But whenever temptation takes the form of woman I can put it away at once by thinking of the beautiful steroid formulas. It has been as simple as that.

But here I am, aided and abetted by your Admissions Committee's policy towards women, my heretofore unwavering celibacy has been shaken by the mere presence in my laboratory of Kitty Foster. Those wolfish instincts of mine, so long dormant, have begun to take over again and I find that no amount of concentration on glucosteroids can drive out what I have previously always classified as "mush." Events and people in my environment have changed and, thanks to you, it is becoming difficult for me to concentrate on my work. The glucosteroids may well be my life's work, but at the moment I have a conviction that it is the ketosteroids that are relentlessly driving me in my daily activities.

It is quite true: She comes from Nebraska; she was Phi Bet at Radcliffe; and her father owns half of Omaha; and she is an only child. It is quite true that whenever boys work with her, their marks hit the skids. And now, in spite of herself, she is affecting the Faculty.

Intellectually she is miles ahead of her classmates. She is almost an authority on enzymes; she can take you around the Krebs cycle clockwise and counterclockwise. She seems to understand the intricacies of potential changes across the cell membrane, and she has read Malinovsky's papers in the original Russian. Now, she asks me to let her repeat his work in our lab this summer! It would be acceptable if this intellect were encased in a somewhat more humdrum human form, but here, in Kitty Foster, we have the intellect of an Einstein around which is molded the personality

"I was suddenly aware of a subtle perfume . . ."

"Her mind is razor sharp . . ."

and form of a goddess, and it is this that makes her unbearable in the Department.

This veritable catalytic agent has been brought to Harvard by your Admissions Committee, Ken. You could have foreseen its effect upon us and I can only guess what her effect upon the productivity of our Department is going to be. I know what you are going to ask, "Are you having her this summer in your lab?"

Of course I am. The girl is brilliant. Her mind is razor sharp and a most fascinating instrument. Far be it from me to punish her because she is beautiful. But from now on, please pick minds in more ordinary garb. This is my plea. I am diving into this summer headlong, and will let you know more later.

Sincerely,

Jonathan Zanchovitch
Professor
Department of Biochemistry
Building D

Dr. Hastings Begins Phase Three

In a few days I am closing Phase Two in my life, embarking on Phase Three. The Phase Three which is in prospect makes Phase Two, my Harvard years, not a finale but a period of adult education and growth.

I had hardly more than arrived at Harvard, when I heard President Conant state in his Tercentenary Address in 1936, "Harvard was founded by dissentors. Before two generations have passed there is a general dissent from the first dissent. Heresy has always been in the air. We are proud of the freedom which has made this possible, even when we most dislike some particular form of the heresy we may encounter."

It must have been this spirit which gave me the courage to talk on Trends in Pre-clinical Teaching 20 years ago, after having taught only two classes of medical students, and never having seen one until I came to Harvard. I want to quote a little from that 20-year-old speech. I said (and I was most surprised to find this): "There is a widespread realization today of the importance of relating the facts obtained in individual pre-clinical disciplines, not only with each other but with the clinical sciences as well. The era of excessive pride in artificial intellectual boundaries based only on convenience seems to be passing." A little further on I said, "The present generation of first-year medical students are acquiring the habit of using physiology and anatomy, chemistry and physiology, and both physiology and histology in chemistry. This breakdown of the hard and fast divisions between the sciences of the first year, is, I am told, also becoming true for second-year subjects. It is to be hoped that the development of this habit of continuity of thought and use of scientific information from course to course and year to year can be fostered through the clinical as well as through the pre-clinical years." Then I told the following story: "I had an interview last week with the oldest member of our department, Mr. Henry Martin, a most dignified English gentleman, who presided over our storeroom. In view of the fact that he'd passed out unknowns to 43 of Harvard's classes, I regarded him as highly competent to brief me on trends in pre-clinical teaching. So I asked him to come up to my office. I said, "Mr. Martin, you must have seen many changes in your period of service." He looked up at the ceiling and said, "Well, Professor, I wouldn't say that things have changed very much. When I came in '95, Professor Wood was interested in blood. Then came Professor Folin in 1908, and he was interested in the urine; now you come, and you're interested in blood again. No, I wouldn't say that there had been much change." Had I remembered this remark of Mr. Martin's last year, I might not have been so apprehensive and grouchy about the change in the curriculum.

I have asked myself, "Is there a biochemistry?" And I've decided there is not just one biochemistry, there are as many biochemistrys as there are people who use it; as many as there are people who use chemical methods and chemical concepts to study living matter. Even those of us who teach it, as if it were a captive and domesticated body of knowledge, don't agree on what it really is. I like biological chemistry very much, especially when I can use it in relation to physiological and medical problems. That's what I'm going to do beginning January 1. Whatever biochemistry is today, it owes as much to clinical medicine for its high place among the biological sciences as medicine owes to it. A hundred years ago this wasn't true. Chemistry was pretty well advanced, but medicine had little or nothing to do with it. Indeed, professors of medicine, such as the eminent Robert Graves, were openly hostile to chemistry. In spite of the distinguished Dr. Graves, and his colleagues who applauded his sentiments, the last half of the last century saw chemistry become an exact science, with chemists taking more and more interest in physiological and medical problems. Beginning with the turn of this century, something happened, particularly in this country, which has changed the course of medicine and has resulted in the mushroom growth of the biochemistry that pervades the biological and medical world today. One of the most important factors in the growth of biochemistry in this country was the development of the simple and accurate method of quantitative analysis requiring small amounts of blood or other materials. The student and physician had new powerful tools to aid in diagnosis and to guide the progress of therapy, and, if they were the inquisitive sort, to acquire new knowledge about disease. Medicine became quantitative. This is what this century will be known for in medicine. This gave American medicine its commanding position. Many men contributed to these methodical developments. But two, in the first half of this century, stand out as pre-eminent. One was my distinguished predecessor here, Professor Otto Folin, who with Wilkes, introduced a system of blood analysis with small amounts of blood and also established the first wholly quantitative laboratory course in biochemistry for medical students right here in this Quadrangle. The other was Donald Van Slyke, of the hospital of the Rockefeller Institute, ingenious in devising methods for the study of clinical problems, who with the late John B. Peters, codified quantitative clinical chemistry.

Harvard's share in this century's pre-war growth of biochemistry was very great indeed. In addition to Folin, there was Cyrus Fiske, who with several others, discovered phosphocreatine and also adenosine triphosphate, simultaneously and independently with Lohmann in Germany. This revolutionized our ideas of metabolism and how muscles work. And there was L. J. Henderson, one of the greatest minds that Harvard has ever had; the best synthesizing mind, I think, that physiology and biochemistry have known. Edwin Cohn's basic and comprehensive physical medical

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Dr. A. Baird Hastings, who for 23 years has guided Harvard's medical students, Ph.D. aspirants and graduate physicians in biochemistry, retired on December 31 as head of the Department of Biochemistry and Hamilton Kuhn Professor of Biological Chemistry.

On January 1, Dr. Hastings joined the Scripps Clinic and Research Foundation at La Jolla, California, as a member of the resident research staff to continue his research in intermediary metabolism and in the application of biochemistry to the study of disease. His remarks before the Faculty have been shortened slightly.

characterizations of proteins led, during the war, to the development of a new family of therapeutic agents. James Gamble, a protégé of Henderson, successfully and practically interpreted the theoretical implications of Henderson's deductions and made salt, water, and acid base balance control understandable to both medical students and physicians. Two of Folin's Ph.D.'s got Nobel prizes: James Sumner for first crystallizing an enzyme, previously regarded as an impossibility, and Edward Doisy either for his work on estrogens or on Vitamin K. I have just taken a poll of my department and we have an equal number who think he got it for one, and an equal number who think he got it for the other. These men brought new "know-how" to medicine, and others like them were doing the same thing at sister institutions. I can't resist mentioning at this point that Folin was a Ph.D. in Organic Chemistry and Cohn a Ph.D. in Zoölogy from the University of Chicago. Fiske, Henderson, and Gamble were all Doctors of Medicine, there wasn't a professional biochemist among them.

And yet it is little short of disgraceful that I have been unable to teach as good a course in biochemistry as our medical students deserve, simply because the entire requirements in science are so low and experience in quantitative analysis is not required. The only recommendation that I am going to make to you is this: Raise, for goodness sake, raise, the minimum preparations required in the natural sciences from its present pitiful low of 25 per cent of his college time. No man today who goes through college should have less than that time, whatever his degree. It is the medical profession itself that biochemistry has to thank for its tremendous growth in this century. But if it had not been for the Folins and the Van Slykes and the resulting enthusiastic support of biochemistry by their clinical colleagues, I doubt whether we would have had the phenomenal growth in numbers, and resources, and in scientific achievements that have marked this life of biochemistry.

I am soon off to work again in the laboratory as a biochemist, or whatever they choose to call me — the physician who studies disease. And what could be a finer prospect than this for me, at my age? Only one that I can think of, and that would be to be 40 again, and just starting to teach the first of 25 classes of Harvard medical students.

ALUMNI NOTES

1896

On the eve of his 86th birthday, **Joseph F. Hawkins** was honored by a group of his medical friends who gathered at the Wayland Manor in Providence. He has been in active practice in Providence for 58 years.

1899

Eugene E. Everett has moved from York Beach, Maine to Punta Gorda, Florida.

1903

From Santa Barbara, California, **George O. Clark** writes that though he is retired from practice he has not resigned from membership in the Aesculapian Club. He was present at the exercises at the Medfield State Hospital when the new Administration Building was named and dedicated in his honor.

1911

Jacob Baldwin Bruce writes: "As an old man of 73 I was able to enjoy a pleasant three months' trip in the summer of 1957, going from St. Petersburg, Florida to Toronto, Great Lakes, Winnipeg, Banff, Lake Louise, Vancouver, Victoria, Alaska and return." Describing himself as a "bitter opponent of fluoridating a public water supply" Dr. Bruce comments: "The Medical School should give scholarships or grants for those students, scientific in purpose, who would desire to investigate fluoride research, because this condition at the present time can be classed in the 'medical unknown' and our Medical School should take the lead and see to it that our students and postgraduates are given the opportunity to become educated to their potential."

Frank P. Gaunt sends greetings to all his Class, "especially to those in my section and fellow interns," and reports that he is still active in general office practice in Webster Groves, Missouri.

1912

Izak Alcazar retired from active practice in December, 1948, and has been living in Long Beach, California.

Lewis W. Hackett became President of the American Society of Tropical Medicine and Hygiene on November 8, 1958.

1913

"Very well and chipper and working about the same as always. Very sorry to miss the Class Reunion because of a bad cold," writes **William P. Buffum.**

Harold M. Frost has a full-time rural general practice in Friendship, Maine.

1915

G. Percy Brown writes: "Have some nice new fall blooming iris, hybridized."

From Mackinac Island in Michigan where his wife and he have retired from his California practice, **Kenneth L. Dole** writes that he is "helping with medical care of the force, and Assembly visitors at the World Center for Moral Re-Armament."

G. Philip Grabfield, now retired for five years, is devoting himself to an earlier love, history, and reports that time passes even more rapidly than in his medical days.

John H. Penix, '11, of Flat Rock, Michigan, suggested this design for the new, forty-nine-star flag.